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THE MENTAL STATE OF HYSTERICALS

A STUDY OF MENTAL STIGMATA AND MENTAL ACCIDENTS

BY

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IN MEMORIAM

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PREFACE

I AM happy to recommend to the medical public the book of one of my pupils, M. Pierre Janet, on the mental state of hystericals. These studies, begun a long time ago, have been completed in my service and set forth in a few lectures which M. Janet delivered this spring at the Salpêtrière. They confirm a thought often expressed in our lectures, namely, that hysteria is largely a mental malady. This is one of the features of this malady we should never neglect if we wish to understand and treat it.

M. Pierre Janet wished to unite as completely as possible medical studies with philosophical studies; it was necessary to bring together these two kinds of knowledge and these two educations in an effort to analyse clinically the mental state of a patient.

J. M. CHARCOT

PARIS, November 1st, 1892.

My wife had completed this translation, and it was in the hands of the publishers, before her paralytic attack on the 12th of last January, which ended fatally on the 21st of May. The reading of the proofs devolved, in consequence, upon myself and my son, Eugene Rollin Corson, M.D., in which most valuable aid, in questionable points, was, at times, afforded by my colleague in the University Faculty, Edward Bradford Titchener, Ph.D., Sage Professor of Psychology.

HIRAM CORSON.

The Cornell University,
September, 1901.

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INTRODUCTION

"HYSTERIA is a general disease which modifies the whole organism."[1] If it disturbs nutrition and all the physiological functions, it disturbs also the psychological phenomena which are one of the functions of the organism. It is these psychological perturbations produced by hysteria in the mental state of the patients, a state considered as a function of the superior centres of the encephalon, which it is my purpose to examine in this work. There is no reason why we should begin over again here the old quarrel about the physical and the moral, which, from a scientific standpoint, is altogether idle. The physician simply sets forth the phenomena which appear among the patients; he considers them all alike real; at least, they are expressions of an unknown reality, and he endeavours only to establish between these facts the bonds of a strict determinism. Whatever be, then, our metaphysical opinions, the study of the *morale* of a patient should be part of every clinical description of him, and the mutual relations of the psychological phenomena, as well as their physiological relations, should be minutely investigated. It is thus only that medicine will be able to acquire the knowledge of the whole man and understand the diseases that affect the whole organism.

Former researches in the automatic phenomena of the mind have led me to study hysterical patients who present these phenomena in the highest degree of clearness. These studies, or at least some of them, have been gathered into a philosophic thesis presented at the

[1] Briquet, *Traité de l'hystérie*, 1859, p. 517.

Sorbonne in 1889. We should like to take them up again to-day from a different standpoint. Instead of accidentally connecting the description of the patients with the study of philosophic problems, we wish to describe the patient in and by himself. The psychological studies will be accessory and will serve only better to explain the morbid phenomena in which, " without any possible dispute, the psychical element plays a considerable rôle when it is not predominant." [1] We shall have occasion sometimes to refer the reader to former works in which these philosophic questions are more thoroughly discussed than it is possible to discuss them in a medical work. The method of observation plays the principal part in these researches: it is the clinical method applied to the diseases of the mind. Experiment confirms it in only a small number of cases, and this experiment, even, is very often but a more precise and better systematised observation. We must distrust complicated experiments on the mind, which are not easy to make; they are often sufficient to upset the mental state we wish to study. Psychology is not yet advanced enough to admit of many precise measures. The general nature of the phenomena, their thousand variations, their changeable conditions, are not sufficiently known for us to boast of measuring any one isolated fact. It is useless and even dangerous to take a microscope and engage in rough anatomy; we expose ourselves thus in not knowing what we look at. We believe that we should, before all, know well our subject in his life, his education, his disposition, his ideas, and that we should be convinced that we can never know him enough. We must then place this person in simple and well-determined circumstances and note exactly and on the spur of the moment what he will do and say. To examine his acts and words is as yet the

[1] Charcot. *De l'isolement dans le traitement de l'hystérie*, 1885; *Leçons sur les maladies du système nerveux*, 1887, iii., p. 238.

best means of knowing men, and we find it neither useless nor wearisome to write down the wandering speeches of a lunatic. The reader will not be surprised, therefore, if we happen to describe an action in detail, to quote a phrase pronounced or written by a patient. The words, the writings of patients, are instructive documents, the graphics of pathological psychology; of course they have to be interpreted, but we must never forget them or transform them.

Although statistics may not be of great importance here, and observations are not very numerous, it is right to inform the reader of the number of patients that were examined and of the conditions under which the observations were made. The remarks which we set forth are founded upon one hundred and twenty observations on hysteria which we have gathered, with most of their possible details, and upon a dozen others furnished by our friends with a kindness we fully appreciate. The first cases we formerly described were studied at Havre, thanks to the assistance of my excellent friends, M. Gibert and M. Powilewics; but the largest portion of these observations are new; they were gathered during our work in the hospitals of Paris, in the service of our eminent masters, M. Jules Falret, M. Guyon, M. Siredey, M. Cornil, M. Landousy, M. Hanot, and especially in the very excellent service of Professor Charcot, who was kind enough to accept us as one of his pupils at the Salpêtrière. When we came to work in the service of M. Charcot, the sympathy, the friendship of all we met endeared to us the clinical service of nervous diseases, and if our humble works can add some small detail to the valuable researches that have been made in it we are happy to offer them to him.

It is impossible, without much complicating the editing of these studies, to allude to all these patients; according to a process we have already employed and

which appeared convenient to us, we shall always cite in preference the same persons, who, once well known, will enable the student to understand the descriptions more easily. These patients are not selected by chance, of course; they are chosen from among those who have been longest studied and who, from different standpoints, presented the most characteristic symptoms. Comparisons show the degree of frequency of each phenomenon and its degeneracy among those subjects who exhibit it in a more degenerate state.

Hysterical symptoms, while maintaining continually, in a certain sense, the same character, present themselves, nevertheless, in two different ways: at one time they are *essential*, characteristic of the disease; at another they are *permanent*, and last about as long as the least indication of the disease remains; in short, they are, up to a certain point, indifferent to the patient, doubtful; the patient feels weakened, yet cannot exactly tell from what he is suffering;—again, on the contrary, they are *accidental*, superadded, in a way, to the disease to which they do not necessarily belong; they are *transient*, or, at most, periodical and *painful* to the patient, who knows exactly what most torments him. This difference has given rise to the classical distinction of *stigmata* and *accidents*. The distinction is sometimes quite easy to make, as it is easy to say that an anæsthesia is a stigma and that an attack is an accident; but often it happens also that a symptom may be in one or the other category. We shall, however, keep this distinction, which is convenient, and divide this study of the mental state of hystericals into two parts:

1. Analysis of the *mental stigmata*.

2. Examination of the *mental accidents* of hysteria.

The present volume of this work will treat only of the stigmata; we reserve for a second volume the examination of the mental accidents of hysteria.

The same patient, during the development of hysteria, may present all kinds of accidents, as numerous as they are varied. We do not intend to describe them all, nor to study in detail the methods which permit us to make in each particular case the difficult diagnosis of such or such hysterical accident. Very many papers have been published on these studies, and the remarkable treatises on hysteria which have recently appeared have united and completed them. We wish simply to draw attention to a characteristic which forms an integral part of most hysterical accidents. An hysterical accident is not only a physical, it is at the same time a moral, accident. The disturbance exists not only in the limbs or in the distal portions of the nervous system; it takes place in those parts of the cerebral cortex which preside over the psychological functions, and a certain disorder of these functions plays an important part in every hysterical accident.

This mental disorder is evident in certain accidents, such as somnambulisms or deliriums; in other cases it is masked. M. Charcot, in his celebrated lectures on the hysterical paralyses of psychic origin, has shown how necessary it is, in all such cases, to trace, so far as may be, the psychological disturbance, and the part it plays in the disease.

We should like, in this work, to follow the advice given by our eminent master; and, while acknowledging the existence of the various organic alterations met with in hysteria, to show clearly the psychological disturbance which always accompanies them. This study will, in the first place, enable us to complete the clinical description of an hysterical accident by adding thereto the analysis of interior and moral symptoms, which should never be overlooked. It may also have another advantage. The accidents of hysteria appear, at first, indefinitely varied, and seem, in many cases, hardly to be connected with each other.

When we study their moral, instead of merely their exterior and physical, aspects, we are made aware that these accidents are much less unlike than was at first supposed. This fact will, we think, be readily apparent; and it will not be necessary to demonstrate it by means of theories or psychological interpretations; it will be sufficient to bring the observations into juxtaposition.

This work is but a synopsis of psychological observations made upon hysterical patients, and brought together for the purpose of comparative study. We hope thus to make some contribution, however slight, to the study of hysteria, and to add new proofs to the conception of the unity of the hysterical malady which has been long maintained by the most eminent clinicians.

Finally, the analysis of these moral phenomena will enable us to distinguish them from all mental disturbances, to which they seem closely allied. Mental maladies are not to be all confounded with each other. If the hysterical patient presents, in her various accidents, mental disturbances, it would not be characterising her correctly simply to call her insane. She is not insane—at least, in the usual acceptation of the word. The diagnosis of her case would be difficult, no doubt, and would require a psychological analysis of the different forms of insanity. This analysis has not, as yet, been brought to its possible completion. Medical psychology will, ere long, however, give to these studies the requisite degree of precision. In the meantime, we hope to contribute somewhat toward an adequate characterisation of certain hysterical phenomena. This science is unquestionably destined to solve a problem which is, as yet, but little more than indicated; which solution will determine the place hysteria should occupy in a classification of mental maladies.

PART I

MENTAL STIGMATA

CHAPTER I

ANÆSTHESIAS

THE insensibilities which we very often observe among hystericals do not at first seem the most important symptom of their malady; other phenomena, apparently more serious, have much more impressed the first observers. Therefore, although this characteristic was known a long time ago, as is proved by the investigation of the devil's sign among witches, it has been omitted in many old descriptions. Sydenham (1681), Louyer-Villermay (1816), Georget (1824), Landouzy (1846), make no mention of it. It is only fifty years ago that this essential symptom was pointed out by Piorry (1843), Macario (1844), Gendrin (1846), Henrot (1847), Skokalsky, E. Mesnet, A. Voisin, and especially by Briquet, who, in his beautiful book (1859), has so carefully described most of the subjective phenomena presented by these patients.[1] M. Charcot, in his lectures of 1872, brought out not only the reality and the frequency of this characteristic, but also its extreme importance for the diagnosis and study of hystericals.[2]

[1] *Résumé historique d'après Pitres. Leçons cliniques sur l'hystérie*, 1891, i., p. 59.

[2] J. M. Charcot, *Leçons sur les maladies du système nerveux*, 5e édition, 1884, p. 300.

Anæsthesia, in fact, is an excellent symptom for diagnosis; it is clear, easily appreciable, and very characteristic for the physician; it is little known by the patient and hard to simulate.[1] It must also, we think, play a great part in the theory of this malady, for it does not exist to the same degree and under the same form in other disorders of the mind, and it may be considered the typical symptom of hysteria. Lastly, it is very valuable for psychological investigation; sensibility and insensibility, while being psychical, have marked objective manifestations. We can pretty well determine whether a member is sensitive or not, and anæsthesia is the most convenient psychological symptom to study experimentally. If we, moreover, recall the large part all psychologists assign to the sensations in the formation of the intelligence, we shall understand that for all these reasons the study of anæsthesia should be foremost in the analysis of mental pathology. In this study,[2] it seems useful to insist from the first upon the characteristics and the general interpretation of this anæsthesia, and to leave to the end of the chapter the special treatment of the particular forms of anæsthesia, which shall be presented as complementary and as a verification of general hypotheses.

§ 1—CLASSIFICATION AND GENERAL CHARACTERISTICS

A great number of patients suffering from hysteria, in conditions in which the normal man would experience a more or less strong sensation, behave as if they felt nothing at all; they do not react, and they do not complain if you pinch them, or prick them, or burn them; if you

[1] Pitres, *op. cit.*, i., p. 79.

[2] This chapter on anæsthesia reproduces in part and completes a lecture given at the Salpêtrière in the service of Professor Charcot, 11th March, 1892, and published in the *Archives de neurologie*, May, 1892.

question them, they declare that they heard nothing, and saw nothing, of the object you placed in a bright light before their open eyes. It is this condition of the patient that is designated by the name *anæsthesia.* This anæsthesia does not exist absolutely with all patients, and we must not reject the diagnosis of hysteria for the simple reason that this symptom in no degree exists; there are, as will be seen, other subjective symptoms, less clear, and above all less pathognomonic, which may in certain cases be substituted for this one. But this anæsthesia exists certainly under one of its various forms in the majority of cases, and may be considered entirely characteristic.

Hysterical anæsthesia may be more or less complete, and be sometimes confined to a diminution of normal sensibility, a hypoæsthesia more difficult to determine. It may bear on all the sensations which the human mind is susceptible of experiencing. Absolutely all the senses —the tactile sense, the muscular, the olfactory, taste, hearing, vision, etc.—may be separately attacked or simultaneously. The sensitiveness of the mucous membranes, at least of those that are accessible, is modified, as well as that of the skin; we know what importance certain clinicians, like M. Chairou, give, not without some exaggeration, to the anæsthesia of the mucous membrane which covers the epiglottis and the pharynx.[1] When a sense is complex, it may be attacked partially, one element disappearing while another remains. The hysterical may lose the so-called tactile sensibility, or only the sensation of pain, that of heat, that which is provoked by the electric current,[2] that which the torsion or pulling of the joints provokes, etc. Sight may be

[1] Gilles de la Tourette, *Traité clinique et thérapeutique de l'hystérie*, 1891, p. 185.

[2] Charles Richet, *Recherches expérimentales et cliniques sur la sensibilité*, 1877, p. 279.

attacked in its various elements, visual acuity, the sense of colours, the extent of the visual field. In a word, there is no sensation acknowledged by psychologists that cannot be modified or suppressed by the anæsthesia of these patients.

Whatever be their seat, these anæsthesias may present themselves under varied forms, which may be gathered into three principal divisions: they may be called *systematised*, *localised*, or *general*.

Systematised anæsthesias are, we think, more frequent than is generally supposed, for they are not always noticed. They do not bear on all the sensations arising from the excitation of a certain sense or of a certain point of the body, but on a group of sensations forming a system, allowing the knowledge of all the other phenomena which impress this same sense or this same point of the cutaneous surface to reach the consciousness. This kind of insensibility, much studied by the old magnetisers, is easy to establish during the hypnotic sleep by appropriate suggestions. The subject, for example, will see all the persons in the room, but will neither see nor hear a certain person pointed out to him; he will be able to see objects, papers presented to him, but will not be able to see certain papers marked by a cross or an uneven number. The analysis of this phenomenon has been the starting-point of the study of hysterical anæsthesias, which are, more than people believe at first, similar to this model.[1] This systematised anæsthesia is also met with, and naturally so, during somnambulisms, whichever way they arise. The somnambulist can see only a certain category, a certain system of objects in relation with his

[1] *Sur les anesthésies systematisées*, voir deux études précédentes : *L'anesthésie systématisée et la dissociation des phénomènes psychologiques* (*Revue philosophique*, 1887, i., p. 449), et *L'automatisme psychologique*, 1889, p. 271. La provocation expérimentale de ces insensibilités systematisées sera étudiée dans le second volume de cet ouvrage à propos des suggestions.

dream; but although he has his senses open to those objects, he seems insensible to all others. The hypnotised subject hears his hypnotiser and does not seem to hear any other person. The automaton, so well described by M. Mesnet, sees only his own match and not those the people around him try to offer him. A natural somnambulist, whom we have described, saw very well that the lamp she had brought with her needed attention, but did not see the people before her who tried in vain to attract her attention.[1] Lastly, the same fact may also present itself naturally when the patients are awake. We studied formerly a young girl who had appeared very strange: both her hands were wholly anæsthetic, but she always recognised by contact two or three objects belonging to her habitual toilet, her earrings and her hairpins, which were of shell. Any other object put into her hands, a gold piece or a pencil, was not felt at all. Another patient, whose hands were likewise wholly anæsthetic, knew always simply by contact and without a mirror, whether her head-dress was arranged according to her taste.[2] We may read in the work of M. Gilles de la Tourette a similar observation: there are hystericals, he tells us, who continue to have the sense of taste for certain things when they seem to have lost that for all others; one patient could no longer distinguish anything but onion-juice.[3]

In all these cases it seems that sensibilty and insensibility are distributed, not according to any physical modifications of the sense itself, but according to certain ideas of the patient which determine the choice of the impressions, whether felt or not felt.

Localised Anæsthesias.—We give this name to complete insensibilities having their seat in a particular region of

[1] "Electivité ou esthésie systématisée," *Autom. psych.*, 1889, p. 287.
[2] *Ibid.*, p. 287, 291.
[3] Gilles de la Tourette, *op. cit.*, p. 183.

the body; no stimulations made on that region produce any sensation in the consciousness, while the same stimuli made alongside on a neighbouring region are perfectly felt. The most frequent and the most curious of these localisations merits the name of hemianæsthesia, because it occupies one of the lateral halves of the body, and stops exactly at the median line. When it is complete, no painful tactile, thermal, or muscular impression made on this side, which is generally the *left side*,[1] causes any conscious sensation. Anæsthesia of the special senses of the same side does not necessarily accompany this hemianæsthesia, but it often does so. The distribution of the sensibility is not always so simple. A sort of crossing is observable; the hemianæsthesia which has its seat in the face, the arm, and the trunk of the left side, passes over to the leg on the right side, while the left leg remains sensitive.[2]

We have often seen patients with their faces anæsthetic on one side and their bodies on the other. In short, sharply defined spots, islets of anæsthesia, may be seen scattered irregularly over the body without any apparent order.

Among these localised anæsthesias, the most curious were formerly described by Professor Charcot under the name of *anæsthesias in geometrical segments*.[3] Entire members or parts of members, a finger, the hand, or the thighs—become anæsthetic over their entire surface, and the insensibility is limited by lines quite regular, and generally perpendicular to the axis of the member; these are the anæsthesias "in shirt-sleeve" or "leg-of-mutton sleeve," etc. We think we can connect with this class a rather strange distribution which we formerly described

[1] Trois anesthésies du côté gauche pour une du côté droit, disait Briquet, *op. cit.*, p. 278.

[2] Pitres, *op. cit.*, i., p. 133.

[3] Charcot, *Leçons sur les maladies du système nerveux*, iii., p. 345.

as a curiosity,[1] and which we have seen twice since then. This repetition of the observation makes us think that there is perhaps something more in it than chance. Certain patients present the anæsthesia clear on one whole side, but they have reserved bracelets of sensibility intact around all the articulations. Inversely, a patient half-cured of a brachial monoplegia had recovered the sensibility of the arm very clear at the level of her wrist, still partially paralysed. Finally, M. Gilles de la Tourette[2] has called attention to localised anæsthesia quite interesting from a psychological standpoint. Often a spot of anæsthesia is superposed on a part of the body where already another hysterical symptom has its seat, such as a paresis or a spasm. Isabelle, for example, a patient whom we shall sometimes cite, has normally a left hemi-anæsthesia which stops clearly on the median line of the neck, as on the trunk. Often, after an attack, she has spasms of the larynx and of the hyoid muscles, and she can no longer talk. At that moment the left anæsthesia encroaches on the sensitive side and covers up the laryngeal and hyoid regions.

These mappings of the anæsthesia do not evidently correspond to regions anatomically distinct. It is not the region innervated by the cubital or the median nerve that is anæsthetic—it is the hand or the wrist. It is the whole arm, together with the region of the shoulders, which is insensible, and not that part innervated by the brachial plexus. Nor does this insensible part correspond with a vascular area, supplied by one and the same artery, as M. Briquet formerly supposed.[3] No, this localisation is not anatomical; it is physiological, as Professor Charcot justly remarks; but we should like to add a word. This localisation corresponds to a very crude, commonly

[1] *Autom. psych.*, p. 312.
[2] Gilles de la Tourette, *op. cit.*, p. 158.
[3] Briquet, *op. cit.*, p. 281.

applied physiology. When a hysterical has a paralysed hand, where should be her anæsthesia ? On the muscles that do not work—namely, on the forearm. And yet the anæsthesia is nearly always limited to the hand itself and to the wrist. In hysterical blindness, anæsthesia bears not only on the retina, but on the conjunctiva, and even on the eyelids; the amaurotic hysterical has spectacles of anæsthesia on the face.[1] She has lost her eye—not only in the physiological sense, but in the popular sense of the word, namely, all that fills the orbit. It would seem, then, that even in these localised anæsthesias the habitual associations of our sensations, the ideas we conceive of our organs, play an important part and determine these localisations.

General Anæsthesias.—In the third place, although it does not happen so frequently, anæsthesias may invade the whole surface of the body and suppress more or less completely such or such system of sensations. We should add here an important observation, one already applied to the preceding facts, but which now becomes even more important. This anæsthesia may be complete and general, without producing any very noteworthy disturbances, either *objective* or *subjective*, in the emotions which the subject may experience.

Let us first examine the facts *objectively*, by studying the outward aspect of the anæsthetic members. Certainly it sometimes happens that hysterical anæsthesia becomes superposed upon other symptoms, spasms, paralyses, œdemas, atrophies even, as has been recently observed.[2] Sometimes it is accompanied with a certain spasm of the blood-vessels ; in fact, Professor

[1] Féré, "Notes pour servir à l'histoire de l'hystéro-épilepsie," *Archives de neurologie*, 1882, p. 282.

[2] Babinski, "De l'atrophie musculaire dans les paralysies hystériques," *Archives de neurologie*, 1886, i. ; Dutil et Gilles de la Tourette, "Contribution à l'étude des troubles trophiques dans l'hystérie," *Nouvelle iconographie de la Salpêtrière*, 1889, p. 250.

Charcot[1] often noticed a phenomenon which has since been carefully analysed by M. Pitres.[2] This is the absence of any hæmorrhage, and the slight reaction of the anæsthetic skin from pricks which, on the sensitive side, produce redness and a drop of blood. We were struck by this phenomenon on examining our patient, Bertha; we had pricked her forehead with a pin to discover where the anæsthesia stopped. We were very much surprised on meeting her a few minutes later to find her looking very strange; the whole right side of the forehead was covered very clearly with small red spots, while the half of the left side had remained perfectly white. There are also observed sometimes certain modifications in the function of elimination. We have seen hystericals who had no perspiration on the anæsthetic side, or, who, on the contrary, perspired excessively on that side. A singular observation which, we think, needs verification, was kindly communicated to us by M. Tixeron, assistant to the laboratory of the Necker hospital. A young woman, anæsthetic on the right side, had been taking for some time pills of nitrate of silver. They made her take a Barèges bath, at the end of which all the skin of the right side was strongly coloured brown, while the skin on the left side remained white. Finally, M. Vigouroux taught us that, in certain cases, the electric resistance was strongly increased on the anæsthetic side. We have not to examine in this work those physiological modifications which should be studied with more care. Let us note only that anæsthesia may be superposed upon a number of other symptoms. Whatever be the importance of these observations in some special cases, it remains none the less true that very often, and perhaps in the majority of cases, anæsthesia may exist without bringing with it any of those physiological disturbances. It

[1] Charcot, *Mal. du syst. nerveux*, 1884, i., p. 303.

[2] Pitres, *op. cit.*, i., p. 75.

manifests itself very clearly and without any appreciable difference of temperature between the sensitive and the anæsthetic hand, without any trouble in the colouration of the skin, in the production of perspiration, in the circulation, or, in a word, in the nutrition of the parts.[1]

When anæsthesia has its seat in a region the stimulation of which becomes generally the starting-point of a movement, this reflex is not usually altered. There is no use discussing the majority of reflexes; the patellar reflex, the cremasteric reflex, the abdominal reflex of M. Rosenbach, the vascular and the secretory reflexes, the reflexes of the erectile organs, and even the cardiac and respiratory reflexes, succeeding to cutaneous excitations, have always seemed to us perfectly well preserved.[2] If a diminution is sometimes established, we must not forget that these reflexes may be diminished even with the normal man. We also believe with M. Parinaud that pupillary reflexes remain almost always intact, even when there is a complete amaurosis, of a hysterical nature, of course. If we make a restriction, it is that M. Briquet speaks of large and dilated pupils,[3] and that Koenig told us recently of having seen an amaurosis which seemed very hysterical, and, as he said, with a permanent dilatation of the pupil. It is possible that here the amaurosis is superposed upon another motor trouble, but this is certainly very rare. M. Pitres has pointed out another very interesting pupillary reflex which continues steadily despite anæsthesia: "The pupil dilates when you prick or strongly pinch anæsthetic parts of the skin, although the patients do not experience any painful sensations."[4]

We have repeated M. Pitres's experiment on many patients and have reached the same result.

[1] A very complete discussion of this important point in Pitres, *op. cit.*, i., p. 75.

[2] *Cf.* Pitres, *op. cit.*, i., p. 72.

[3] Briquet, *op. cit.*, p. 294.

[4] Pitres, *op. cit.*, i., p. 73.

Other reflexes, on the contrary, raise a more difficult question: they are reflexes very often altered or suppressed in hysterical anæsthesia, the start or the grimace being usually made when someone pinches us or suddenly burns us; the reflex that follows upon tickling, either on the sole of the foot or on the hip; the nausea reflex, after titillation of the pharynx; the palpebral reflex, after touching the conjunctiva, etc. These reflexes, we must say, are very often absent. We believe they are particular reflexes which might be called sensitive, because they depend not upon a precise sensation, but on a general sensation, as a pain. We shall return to it at the end of this chapter, when we shall speak more specially of the sensation of pain.

An anæsthesia may also be the cause of physiological troubles in an indirect way, simply because the subject no longer takes sufficient precautions to protect members he no longer feels. With animals, the members rendered insensible through a section of a nerve are often liable to be contused and otherwise injured. We know how patients, affected by that interesting and recently described affection, syringomyelia, conduct themselves. They have traces of burns on the fingers and complain of burning themselves frequently without feeling it. We have twice noticed a similar accident among hystericals, but it can take place only under special and wholly exceptional circumstances; as a general thing, they can show neither contusions nor burns on members that obviously have sensitiveness neither to pain nor to heat. This anæsthesia does not, therefore, prevent the patient from protecting himself against divers accidents. This relative absence of objective troubles is generally accompanied by a most important *subjective* symptom. This anæsthesia is not noticed by the subject; he does not care for it and generally passes it by unperceived. Sometimes you hear a patient say: " I was touching my forehead,

and it was like the forehead of another person, just as if I touched a table." But such a remark is extremely rare; it is heard among patients who have studied their malady and heard their symptoms talked about. When you watch a hysterical for the first time, or when you study patients coming from the country, who have not yet been examined by specialists, you will find, like ourselves, that, without suffering from it, and without suspecting it, they have the deepest and most extensive anæsthesia. M. Lasègue, who analysed very carefully many of the subjective characteristics of hysteria, has often pointed out this ignorance among the patients. Professor Charcot has often insisted on this point and shown that many patients are much surprised when you reveal to them their insensibility.[2] Recent authors are also agreed on this point.[3] It is far from being the case with anæsthesias of organic origin. That particular symptom of tabes, which Professor Charcot was one of the first to describe, and which he has called the tabetic mask, is well known. The patients lose the sensibility of a part of the face, more or less extensive, but they account for it subjectively, and declare that they experience a horrible feeling in regard to it. Ask hystericals who have facial anæsthesia — and they are legion — whether they experience horrible feelings about it, and they will all tell you that they do not care.

To explain precisely this important difference between hysterical anæsthesia and the anæsthesia of organic origin, it will not be out of place, we think, to relate a little anecdote. We did not obtain it ourselves, but it was given to us by our brother, Dr. Jules Janet. When he was house surgeon at the Pitié with Dr. Polaillon, he had an opportunity to observe the following case: A

[1] Lasègue, *Archives gén. de méd.*, 1864; *Études médicales*, ii., p. 30.
[2] *Mal. syst. nerv.*, i., p. 305.
[3] Pitres, *op. cit.*, i., p. 74; Gilles de la Tourette, *op. cit.*, p. 161.

young girl of about twenty had met with a rather serious accident. She fell through a glass door, and a piece of glass made a deep cut into her right wrist just below the thenar eminence. The hæmorrhage was stopped, and the wound united fairly well, when, a few days after the accident, the young woman presented herself for treatment. She experienced a certain numbness in her right hand, but no paralysis was present. She complained particularly of a persistent insensibility, most inconvenient, in the palm of the hand; this slight anæsthesia about the fingers was in fact complete at the level of the thenar eminence. The case was evidently one of a more or less complete severing of the median nerve, and especially of its superficial branches. But while accepting the observation of the patient, we made a singular discovery. She was an hysterical, and on her entire left side she was completely anæsthetic, of which fact she had not said a word. The physician joked her about it: "How is it, Mademoiselle, you come here complaining about an insensibility that affects but a small portion of the palm of your right hand, while you do not even notice the much larger insensibility of the whole of your left side?" The poor girl looked surprised and ashamed. To our mind she might have replied to her doctor with much more assurance, and said: "Be that as you think, sir, but I came here to tell you what ails me; it is the insensibility of the palm of my right hand that troubles me, and that of my left side has never given me any trouble. You are the doctor; explain it as you like."

The same remark can be made, we think, in regard to all the senses—even the visual sense. There is a disease well known by oculists, namely, pigmentary retinitis, which consists in a progressive sclerosis of the retina, moving from the periphery to the centre. Naturally, such a lesion produces a progressive and concentric contraction of the visual field. But these patients are very

unhappy, and are scarcely able to go about alone in the street, and make perpetual efforts to move their eyes, the visual field of which is diminished, in every direction. Do hystericals suffer pain ? Do those whose visual field is contracted make up for it by movements of the eye-ball? On the contrary, we have often seen young girls whose eyes had their visual field reduced to 5°, that is to say, wholly punctiform, play ball in the yard just like persons of normal vision. They follow the ball in the air and catch it in its flight, while a patient suffering from pigmentary retinitis has trouble in guiding herself in the street with a retraction of 15°.

Hysterical anæsthesia, then, has, in all its forms, characteristics of its own. In its systematised or localised form, it depends upon the ideas of the subject much more than upon the anatomical construction of the organs involved. Even when it is general, it changes very little, and as to the physiological activity of the parts, none at all. It is absolutely a matter of indifference to the patient, who, before it was pointed out to her, was even ignorant of it. Thus we can easily distinguish this form of anæsthesia from the anæsthesias of organic origin.

§ 2—THE PROBLEM OF ANÆSTHESIA

As soon as hysterical anæsthesia was well established and its importance recognised, especially since Professor Charcot's lectures, the analysis of its characteristics and the determining of its nature became a matter of interest. The observers quickly discovered very great difficulties, and perceived that hysterical anæsthesia, apparently so clear at the outset, seemed to be transformed and to elude the student as soon as he wished to study it with precision. M. Lasègue, who had had a glimpse of the true nature of this phenomenon, insisted repeatedly on

showing the singularity of its anæsthesia. He wanted it clearly separated from the anæsthesias due to nervous lesions, and he went so far as to make of it a sort of mental alienation. "I should be disposed to believe," he says, "that the hysterical is, under another form and to another degree, in a similar mental condition to the man afflicted with general paralysis. He, too, explains his indifference in the same way."[1] Let us examine the facts which will gradually bring us to a similar opinion.

An anæsthesia is usually due to a more or less serious lesion of the nervous system; the result of it is generally definitive, or, in any case, the anæsthesia slowly disappears only as the organs are recovering. Now, it is not so with hysterical anæsthesia, one of the first characteristics of which is *mobility*.

Mobility of anæsthesia.—Unquestionably some patients retain their stigmata all their lives: "Aurel is still hemianæsthetic at seventy-five; Ler. has kept a hemianæsthesia and a contraction of the visual field for forty years."[2] We shall have to keep an account of these cases; but generally, and perhaps even among these very patients, without its having been observed, anæsthesia becomes modified and disappears all at once for longer or shorter periods.[3] "It varies from one moment to another," says M. Féré, "and under the influence of causes so slight that they may pass unnoticed."[4]

However rapid in their mobility, some of these changes may nevertheless be studied, and one can note at least some of the circumstances in which they are oftenest effected.

[1] Lasègue, "Anesthésie et ataxie hystériques," *Archives générales de médecine*, 1864; *Études médicales*, 1884, ii., p. 32.

[2] Gilles de la Tourette, *op. cit.*, p. 203.

[3] Ch. Richet, *Recherches sur la sensibilité*, 1877, p. 276.

[4] Féré, "L'énergie et la vitesse des mouvements volontaires," *Revue philosophique*, 1889, ii., p. 37.

1. The attacks modify considerably the localisation of the sensibility. Many authors have noted that anæsthesias often increase at the time preceding the attacks.[1] For example, Marguerite, who ordinarily has right-sided hemianæsthesia, right visual field 60°, left 30°, becomes, during the hours that precede the attack, totally anæsthetic, both visual fields 25°. We point out a case much rarer still; it is an opposite phenomenon. Celestine, usually totally anæsthetic, visual field 10° on both sides, recovers complete sensibility sometimes during a form of excitement which lasts half an hour before the attack.

During the attack itself, when we can obtain a few intelligent signs (we shall see that this is generally possible), the sensibility becomes modified. Often, as it happens with Bertha, it is recovered entirely. After the attack, many patients, like Marguerite, return to their usual condition; others have for some time anæsthesias more extended than usual. Bertha, generally hemianæsthetic on the left side, visual field 5° on both sides, remains, after the attack, totally anæsthetic and at times completely blind for some hours.

2. It often happens, during natural sleep at night, that tactile anæsthesia disappears. It is very difficult to verify this fact. We have to take the patients by surprise at night, using all sorts of precautions not to wake them. We pinch them on the anæsthetic side. They groan, turn over, complain in their dream, or wake of a sudden exactly as a normal person would. M. Jules Janet, when he was house surgeon at Dumontpallier, has repeatedly verified this fact on two patients, the observation of which he communicated to us. We had the fact established on various persons, particularly on Bertha and Isabella. Our friend, M. Dutil, was kind enough to verify the fact for us on an hysterical, G., hemianæsthetic on

[1] Paul Richer, *Études cliniques sur la grande hystérie*, 1885, p. 23; Gilles de la Tourette, *op. cit.*, p. 206.

the left side. Pinched on that side during her natural sleep, she whined and spoke in her dream: "You pinch me . . . how stupid!" etc.

3. During certain intoxications which provoke a transient excitation or bring with them states analogous to sleep, insensibility vanishes more or less completely. Vel., totally anæsthetic, becomes entirely sensitive when drunk. Drunkenness, besides, provokes with her many other phenomena of which we shall speak later. Chloroform anæsthesia, in the period of excitation, does away with all stigmata. The fact has been well described by M. Jules Janet.[1] "Among the most paradoxical consequences of the hypodermic use of morphine," says M. Ball, "we must cite the restoration of cutaneous sensibility with subjects who have lost it. . . . An hysterical drugged with morphine—a dose of eight centigrams a day—felt all her pains disappear and her normal sensitiveness restored. Abstinence brought back her hysterical symptoms."[2] The same fact has been described by M. Jules Voisin.[3] We did not see a complete disappearance (of the pains) but a diminution of the anæsthesia, and a widening of the visual field in hystericals who were under the influence of morphine, some time after the injection of the drug. Many other excitations must have analogous effects.

4. The object of our former works was, above all, the numerous modifications of sensitiveness during states of induced somnambulism. We shall examine later the finer modifications; we note here only the most apparent. Certain subjects, under rare conditions, recover suddenly and completely all their sensitiveness as soon as they are in the second state. This fact has been sometimes pointed out in the old descriptions of hypnotists.

[1] Jules Janet, *Bulletin médical*, 1889.

[2] Ball, *La morphinomanie*, 1885, p. 20–38.

[3] Jules Voisin, *Communication à la Société méd. des hôp.*, May, 1890.

That of Estelle is especially very clear in the remarkable observation which forms the basis of the work of Dr. Despine (of Aix). Estelle's legs were paralysed and, besides, completely anæsthetic; she also presented on her trunk many hyperæsthetic points. "Tell our friend, Dr. de Castella," wrote Despine,[1] "that the sensitiveness is in crisis (in somnambulism) and universal, as it was in the former state of health. That after the crises, the paralysis and the excessive sensitiveness of the back and chest reappear." We have very often established these same facts at the outset of our researches before we had read the very interesting observations of the hypnotisers. We may, among several patients, cite as examples Bertha and Isabella (anæsthesia on the left, and enormous contraction of the visual field, with unilateral amaurosis with the second). As soon as they are in a state of provoked somnambulism, they feel every contact on both sides and have a visual field of 90°.

Sometimes the subjects have, during their somnambulism, an anæsthesia apparently general; but the slightest excitation that directs somewhat their attention upon tactile sensitiveness causes this anæsthesia to disappear,[2] even on parts that remained anæsthetic when awake, despite suggestions. Things took that turn in the observation of Fernande, a case kindly communicated to us by M. P. Carpentier.

This restoration to sensitiveness proceeds somewhat slowly, and becomes evident only when the hypnotic state has been considerably prolonged. Maria, for instance, becomes more and more sensitive and takes a wider visual field when she is allowed to remain hypnotised a long time. She does not, however, altogether reach the normal visual field.

[1] Despine (d'Aix), *Emploi du magnétisme dans le traitement des maladies nerveuses*, 1840, p. 195.

[2] Général Noizet, *Mémoires sur le somnambulisme*, 1854, p. 107.

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Others, again, have a more complicated somnambulism which we shall describe later. They pass through several different states in which sensibility and, above all, memory undergo many modifications. It is only in one of these states, often a state that develops after all the others, that the subjects recover all their sensibilities. We have often described this state in several patients, especially in Lucie.[1] M. Jules Janet has established it anew and very easily on a celebrated hysterical, Wittm.[2] After these states, which we have designated complete somnambulisms, the subject, like Maria, may retain for some time a sensibility more extended than usual, or, as it more often happens, he may return to his habitual state of anæsthesia.

5. Sensibility may be modified even in waking time, and the general condition of the subject will, apparently, not be much changed. M. Briquet has insisted on the action of electricity to reestablish the sensibilities.[3] With some subjects, Rose or Celestine, it was absolutely necessary to have recourse to this remedy, as no other would have met the case. M. Burcq, and many authors after him, have shown that magnets, metal plates, and many other agents, which all vary according to the patients, have analogous effects. This sensibility, increased by these agents, persists a longer or shorter time and disappears with oscillations.

6. The influence of suggestion, in general very powerful with hystericals, may suffice momentarily to re-establish the sensibilities, and to restore, for example, Maria's left arm to entire sensitiveness and enlarge her visual field.[4]

[1] "Anesthésie et dissociation," *Revue philosophique*, 1888, i., p. 269; *Autom. psych.*, 1889, p. 105 *et passim.*

[2] Jules Janet, "Hystérie et somnambulisme d'après la théorie de la double personnalité," *Revue scientifique*, 1888, i., p. 616.

[3] Briquet, *op. cit.*, p. 684; Pitres, *op. cit.*, i., pp. 144, 151.

[4] *Le fait est très souvent signalé par les magnétiseurs; on le trouve aussi*

But it should be borne in mind that this phenomenon is far from being general; that, with a number of patients, sensibility and the visual field change very little when it is suggested, and, on the contrary, undergo great modification under the influence of certain excitations—such as drunkenness, or of certain changes of psychological state—as somnambulism. It is very probable that suggestion or other psychological phenomena intervene in the cases pointed out in the preceding paragraph. Maria's sensibility is easily modified by the application of iron plates, but they must be applied by myself. If we trust her to use those plates herself they lose all their power. We should not maintain, however, that all these facts, especially the action of the electric current, are the only suggestions. These suggestions, in fine, may be made in various ways and will be studied later.

Many other psychological phenomena come in to produce, modify, or destroy anæsthesia. For example, strong emotions, preoccupations, reveries, increase it. The association of ideas may in some cases modify it. We say to Maria that she has a caterpillar on her left hand, and she cries out and pretends that she feels the tickling of it; at this moment the whole of her left arm has become quite sensitive.[1] But there is a psychological phenomenon which plays a far more important part than any other, and its study throws a great deal of light upon the problem; we mean attention. To verify this fact, we must remember, as we shall demonstrate later, that with hystericals, attention is altogether the most difficult thing to fix, and that but a few can succeed in directing it. As a general thing, we may for a moment attract their attention upon their anæsthetic hand by whatever means

dans la neurhypnologie de Braid, traduction, 1883, p. 175, *et dans le livre de M. Bernheim.*

[1] *Autom. psych.*, p. 312.

we please. A patient of M. Raymond[1] does not feel the electric current when he has his eyes shut. He acknowledges a tickling on seeing the manipulation of the process. We fasten a red wafer on Bertha's left hand; she looks astonished and stares at her hand. Let us leave her for a moment; then, when her head is turned, let us lightly pinch that hand, so insensible but a moment ago. Bertha now cries out when we pinch her and feels it quite perfectly. It is true that this fine sensibility will not last long. We take that wafer off and a few minutes later she can no longer feel anything.

All these phenomena, the last particularly, are the origin of many difficulties, for they very easily upset the very sensibility that is the object of the study. They increase the anæsthesia; they fix it or suppress it; they give it an extremely changeable aspect, which discourages the observer.

Contradictory characteristics of the anæsthesias.—Now, it will be asked, at least as long as the anæsthesia exists, does it present itself to the observer definitely? Is it always very certain, whatever way you examine the subject? In no wise; and we have to point out a second series of observations which complicate the problem of anæsthesia still more, for they present it to us not only as changeable, but as *contradictory*.

M. Lasègue said in 1864 that hysterical anæsthesia looked strange, and that it seemed to be a psychological perturbation, a sort of alienation. The studies which subsequently confirmed this theoretical conception were at first observations on an altogether special point, namely, on *unilateral amaurosis*. Some patients seem to have totally lost the vision of one eye. They pretend to be in absolute darkness, for example, when you close their right eye, leaving the left eye open, and yet you

[1] F. Raymond, "De l'anesthésie cutanée et musculaire," *Rev. de médecine*, 1891, p. 389.

cannot discover any lesion, either from the fundus of the eye, or of the retina, and you establish the complete integrity of the pupillary reflexes. Are we not right in examining this symptom closely? The army surgeons in the regiments, very expert in unmasking medical frauds, have applied to amaurotic hystericals the processes they used in their councils of revision. One of these processes consists in having the subjects look into the "Box of Flees." It is a very ingenious little instrument. Thanks to a play of mirrors, the subject that looks into the box, keeping both eyes open, sees at his right an object—a red wafer, for instance—which in reality is seen only by the left eye; and he sees at his left a white wafer which is seen only by the right eye. Let us suppose a malingerer, not forewarned, pretending not to be able to see with his left eye; he will say that he cannot see the object which appears to his left; he will suppress the white wafer and will mention only the red point, which appears to his right. But, this red point can be seen only by the left eye. Now let us show this box to an hysterical, amaurotic in the left eye, and she will fall into the same error as did the malingerer, as Isabella did; or else she will see, more unguardedly still, both wafers, as did a patient of M. Pitres.[1]

A little later, in order to follow what appears to be the historical order, Professor Charcot and M. Régnard have made known an ensemble of observations on a very similar problem—the one, namely, on unilateral and bilateral dyschromatopsy. A patient, for instance, could, of the two colours, red and green, distinguish only the red and did not see the green. Now, if you cause to turn before her eyes a Newton-wheel, on which are painted red and green sections in the required proportion, the patient would see before her a greyish-white tint, as if all the colours produced on her their usual effect. The control experiment

[1] Pitres, *op. cit.*, i., p. 102.

is made by taking a disk really red and white and presenting it to the patient beside the red and green disk. The achromatopsical will at first declare both identical; but as soon as the red and white disk is in motion, she will declare it pale red, which is the truth, while the red and green appear to her greyish, which is equally true. The patient who saw no difference in the two disks when in repose, in which she was mistaken, makes no longer a mistake when they are in motion. "The patient has reconstructed the light with a colour she saw and another she did not see."

In the same session of the Biological Society where this very important observation was communicated, M. Paul Bert asked if the sensations of colour, which had apparently disappeared, produced nevertheless consecutive images and gave place to phenomena of simultaneous and successive contrast. The fact has since been very often verified, and M. Régnard himself has prepared the following experiment: If you ask of an achromatopsic hysterical, bent on the red, to fix for any length of time a red square on a white ground, she will declare that she sees only a grey square; and yet, after a while, she will obtain for consecutive image a green square. "We think, therefore, that it is but logical," said M. Régnard, "to believe that the retina in hysterical achromatopsy is sound, and that the physiological defect which causes the visual error lies farther back in the perceptive centre. When the green vibration reaches this centre it is not judged, but it acts nevertheless; and the proof is, that added to the red vibration, it gives the perception of the white, and produces the consecutive green image." Professor Charcot declared also that, in his opinion, an achromatopsy of this kind was a purely cerebral phenomenon.[1] We now come to the numerous and precise

[1] *Comptes rendus des séances de la Société de biologie, 26 janvier*, 1878, p. 32.

experiments of M. Parinaud about unilateral amaurosis.[1]

The following may serve as example: "Suppose," he says, "a hemianæsthetic patient subject to monocular colour-blindness. A green paper is seen grey by the left amblyopic eye and green by the right eye, which is sound. If we place on the sound eye a prism which causes two images on the paper to be seen, instead of one being green and the other grey, as expected, both will be green." In other cases, a subject, amaurotic in the left eye, sees nevertheless two images coloured, if the prism is placed before his unsound eye. From these and other similar experiments, M. Parinaud concluded that there are two different mechanisms—one for the unilateral vision, the other for the bilateral vision, and that, in hysteria, the first alone is affected, while the other remains intact. M. Pitres, who has repeated and varied these experiments in an interesting manner, comes to the same conclusion,[2] a conclusion which appears to us correct, but somewhat incomplete. M. Bernheim, in 1887,[3] reproduced M. Parinaud's experiments and established materially the same result; but he interprets it differently and makes a phenomenon of suggestion of it. "Let the visual image be perceived, the hysterical will unconsciously neutralise it with his imagination." As will be seen in all this work, and particularly in the last chapter, the stigmata do not seem thus to be phenomena of inhibition, but rather to have the significance of phenomena of exhaustion. Let us for the present remember only

[1] *Cf.* Thèse d'agrégation de M. Grenier: *Des localisations dans les maladies nerveuses*, 1886; M. Parinaud: Anesthésie de la rétine, etc., *Bulletin de l'Académie royale de Belgique*, 1886, et du même auteur: "Sur une forme rare d'amblyopie hystero-traumatique," *Bulletin médical*, 1889, p. 777.

[2] Pitres, *op. cit.*, i., p. 103.

[3] Bernheim, *Revue de l'hypnotisme*, 1887, p. 68.

one thing—that is, that these new facts confirm the opinion of M. Régnard and the still older thought of M. Lasègue on the psychic nature or on the cortical origin of these phenomena.[1]

If the unilateral amaurosis presents these embarrassing problems, it is the same with all anæsthesias. Several years ago we made the following observation about a patient of M. Powilewics's service at the Havre hospital. She was attacked with hysterical paraplegia and presented a state of total anæsthesia. We used to treat her legs with electricity, and noticed the strong muscular contractions she experienced at each contact of the negative electrode; when, all at once, we saw that the two wires which fastened the plugs to the apparatus had dropped. For a long time had we thus been applying electricity to her with simple pieces of wood. We continued without fastening the wires to the ends, and the contractions were all the greater by the simple contact of the plug. This, it will be said, is nothing very wonderful; there is a sort of habit in that, a suggestion that is taking place. We think so, too, but how could this patient, whose skin all over her body, was wholly insensible, and with her head well turned away, feel the moment when the plug touched her legs, and make a movement just then, and only just then ? We may every day experience a similar embarrassment. We propose to Isabella a little contrivance to verify her anæsthesia quickly. She is to answer "Yes" when she feels and "No" when she does not feel anything. As she is very simple-minded, she accepts without demurring, and we discover then a curious

[1] We have published in the *Revue philosophique* (1887, i., p. 460) the observation of a totally anæsthetic hysterical, in whom could be clearly demonstrated all the sensibilities in their latent or subconscious state. It is impossible to follow here to the end the historical order of the publications on the psychic nature of anæsthesia. This order would complicate the problem unnecessarily.

contradiction. Although she has her eyes carefully concealed behind a screen, although we avoid any kind of rhythm and pinch her several times irregularly on the same side before we pass over to the other, she is never mistaken and always says " Yes " when we pinch her on the right and " No " when we pinch her on the left. The same experiment repeated on a man, Pasq., gives exactly the same results, until he perceives the queerness of his answers, and tries to answer attentively. He then ceases, but only then, to say " No " when we pinch his anæsthetic side.

Here is now another observation which bears no longer on the tactile but on the muscular sense. A young woman, twenty-two years old, whom we have often described by the name of Lucy, took during her attacks certain cataleptic poses. She would, for an hour, keep her eyes fixed on the window and her arms raised in an attitude of terror. For the present we must insist on only one detail of this attack: We observed that during the most normal of her waking states it was enough to raise both her arms, and place them in the posture of terror which they took during her crisis, to induce at once an attack. Of course, you will say the thing is quite simple and well known. By the position of the arms you call forth the principal idea of the attack and the rest follows. True, but there is one little detail yet. Lucy was anæsthetic over her entire body, and presented nowhere any trace of muscular sense. As it often happens in this case, she would fall down at once as soon as you closed her eyes. Now, we have often taken the precaution to close her eyes before displacing her arms, and the crisis occurred all the same as soon as the members had the required position. How do you explain the notion of that position being appreciated by so insensible a subject ?

The preceding process, which consists in inducing an

hysterical crisis by means of those sensations which seem to have disappeared from the mind of the subject, allowed us to establish the same difficulty in regard to another very important symptom—namely, the contraction of the visual field. Georges, a lad of sixteen, had had his first attack of hysteria in consequence of a great fright on the occasion of a fire. He repeated that scene on each of his attacks; cried "Fire!" called the firemen together, and fought against the flames. Besides, it was enough, when he was quite calm, to speak of fire before him, to show him but a little flame, to provoke immediately a return of the attack. One day we placed him before a perimeter, as if to measure his field of vision. We caused him to close the right eye and with the other eye to fix the central point. He expected to see advancing on the arc of the blackened circle, as he had often seen it, a piece of paper. But we kept carefully concealed behind his back a lighted match and extended it gently to the extremity of the arc. The match was scarcely at the 80th degree when the patient uttered a loud cry—"Fire!" —and fell back in convulsions. There was nothing astonishing in that, certainly, since we have said that the sight of a flame brought on a crisis. But here we meet again an obscure question. The patient, on his left side, had, as we had often measured it, his visual field contracted to 30°, to a maximum 35°, and the match, being at 80°, was evidently placed in the part of the visual field which was invisible, its image projected over the anæsthetic part of the retina. This experiment, slightly modified, is repeated without difficulty with Bertha, who has, however, both sides of her visual field contracted to 5°. We have accustomed her to fall asleep when she sees our finger raised before her; this is one of those well-known suggestions of marked points (*points de repère*). Well, we place her before the perimeter, the right eye closed and the left eye fixed on the central point; we

move our finger slowly on the arc of the circle: it has not yet reached 80° when Bertha has already fallen backward hypnotised [1] (Fig. 1).

The preceding experiments have been ingeniously reproduced at Bordeaux by M. Laurent:

Josephine S.—he says—is a young girl of nineteen who became hysterical from having been frightened by a mouse as she

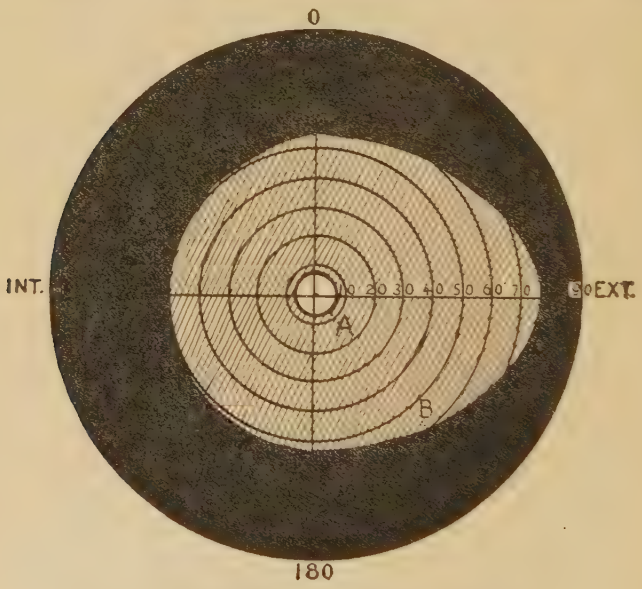

FIG. 1.—BERTHA'S VISUAL FIELD—LEFT EYE.

A, Limit of the conscious visual field in which the subject perceives the vision of the index. B, Limit of the subconscious visual field, in the interior of which it suffices to place the finger for the subject to fall asleep.

was going to get wood in the cellar. Since that time, the sight of a stuffed mouse gives her invariably a cataleptic fit. With the assistance of M. Sabrazès, we measure her visual field and we convince ourselves that its area does not exceed 20°. This

[1] *Archives de neurologie*, May, 1892.

done, the patient still fixing the central point of the campimeter, we bring near the board a stuffed mouse, and the patient falls into a cataleptic fit when the animal comes between 50° and 55°, consequently far beyond the area of clear and conscious perceptions.[1]

All these facts, and a great number of others which have accumulated, are very likely to puzzle the observer. They show us that hysterical anæsthesia not only changes from one moment to another, but, indeed, varies in the same instant, and manifests itself by contradictory phenomena, according to the questions put to the subject.

§ 3—ATTEMPT AT INTERPRETATION

It is hardly possible ever to explain anything completely. We have to content ourselves with referring one problem to another more general. We have never pretended to explain hysterical anæsthesia, and even now, in this first chapter, cannot discuss the relations of anæsthesia with suggestion and fixed ideas, because we have not yet studied these phenomena nor their conditions. We must be satisfied with gathering the facts, apparently contradictory, which have been collected, and bringing them under a simple formula which does not explain them, but which embraces them, and which may be taken up again later for further explanation, if possible, bringing it close to other facts. We should be satisfied now with finding such a formula.

A first interpretation of facts should be quickly put aside. The anæsthesia of hystericals is extremely changeable and contradictory. These patients pretend not to feel, and by very simple artifices we can prove to them that they feel perfectly well. Their insensibility is, therefore, simulated, and our processes are only means to

[1] L. Laurent, "De l'état mental des hystériques d'après les théories psychologiques actuelles," *Archives cliniques de Bordeaux*, September, 1892.

deceive a deceiver and unmask a fraud. This résumé of facts is, to our mind, altogether crude and insufficient. Do hystericals take any particular interest or pleasure in having their arms pierced through with needles? Do these young girls pass through the council of revision to simulate unilateral amaurosis? How is it that, in all civilised countries, hystericals should have agreed to simulate the same thing ever since the middle ages to the present day? If the hystericals *did* simulate, would they allow themselves to be caught in snares as obvious as those that are laid for them? Lastly, did they come here to boast of their anæsthesias? Why, all authors have established that these patients are ignorant of them. It is we who reveal them to them, and they might say to us: "If you are not satisfied with our insensibility, do not speak of it; it is not we who have made it known, and we do not particularly relish the reputation of being insensible creatures."

We must not be content with these crude explanations, and since anæsthesia presents itself to us as a psychological fact, we must seek, among the few notions psychology furnishes us, that which best summarises facts of this kind. We are happy to have M. Lasègue confirm an opinion which we have maintained for several years: hysterical anæsthesia is a certain species of *absent-mindedness*. "A person," said M. Lasègue, in 1864, "absent-minded through a great preoccupation, does not perceive sensations which, in another frame of mind, he would scarcely have tolerated. . . . It is probable that hystericals, whose moral state offers so many other singularities, acquire likewise, through their very malady, a sort of laziness that renders them less apt to perceive certain psychic modalities."[1]

Absent-mindedness, in fact, even in the normal man,

[1] Lasègue, "Anesthésie et ataxie hystériques," 1864; *Études médicales*, ii., p. 32.

produces phenomena equivalent to those of hysterical anæsthesia. It prevents us from feeling the hat we have on our head or from seeing the umbrella we are holding in the hand. It is because of this absent-mindedness that the wounded soldier amid the heat of battle does not feel the pain of his wound. Insensibility thus produced is also mobile and contradictory, for it disappears as soon as we change the direction of our attention, and there remain adequate and intelligent movements. The absent-minded man holds on firmly to his umbrella and does not let it fall, although he is looking for it everywhere. Absent-mindedness with hystericals is abnormal, as we shall see presently, proving right before our eyes that it may give rise to momentary insensibilities, which have all the characteristics of ordinary stigmata. Some hystericals, like Dec., are incapable of feeling two sensations at once; as soon as they experience one they no longer feel the other. Bertha, usually sensitive on the right side, can no longer feel that we prick her with a needle while she is busy watching a dog in the street or talking of the ball at the Salpêtrière. Hystericals, at times obsessed by fixed ideas, as we often see, become more anæsthetic than usual at the moment of their obsessions, and we can guess when Justine or Maria are possessed by their fixed ideas by simply examining their visual field. Therefore, without pretending that this should solve the problem, we believe it may stand for a first approximation of the truth in the formula. The anæsthesia of hystericals is an absent-mindedness.

But it is only a first approximation. To stop here would be falling into that great error which consists in confounding the pathological phenomena with the normal, simply because of their inevitable analogies. Anæsthesia is certainly not an ordinary absent-mindedness. It is much clearer and more enduring. It is far from disappearing so easily as the subject wishes it, and, above all,

it is produced without fixed ideas or objects attracting the attention of the patients elsewhere. In order to understand this metamorphosis, we must examine more carefully the nature of absent-mindedness and especially the nature of sensation such as psychological researches are able to explain.

The phenomena of sensation have been very vaguely defined. Most psychologists accept, in a more or less explicit manner, definitions analogous to those of M. Wundt: "Sensations are primitive states of consciousness which it is impossible to decompose into simpler phenomena."[1] In a word, sensations are supposed to be in psychology what atoms are in chemistry, and this notion seems to be in general quite satisfactory. But most psychologists add immediately another formula to complete and give precision to the first.

"Sensation," they say, "is the phenomenon that passes in the ego when I can say, '*I* feel, *I* see.'"[2] This second definition, far from throwing light on the first, seems to us in complete contradiction with it. The words "I see, I feel," far from being applicable to a simple phenomenon, designate, on the contrary, a very complex phenomenon. One of the two words, "feel," "see," might perhaps be applied to a simple phenomenon, to a psychological atom. A physiologist, Herzen, said that the brain may be compared to a vast hall filled with innumerable small gas-jets. From time to time some little lamps light up here and there, and this is what is meant by the isolated word "feel," "see."[3] But it is far

[1] Wundt, *Psychologie physiologique*, traduct., 1886, i., p. 305.

[2] For these psychological discussions, cf. *Autom. psych.*, p. 39 *et seq.*

[3] Herzen, *Le cerveau et l'activité cérébrale*, 1887, p. 216. This curious comparison had already been made before: "Le cerveau est comme un candélabre à gaz: quand toutes les flammes brûlent, c'est la veille; quand toutes les flammes sont éteintes, c'est le sommeil normal; quand une seule brûle . . . c'est l'état hypnotique."—Beard, *Boston Med. and Surg. Journ.*, 1881, p. 265.

from being thus with the words "*I, me*"; these are terms enormously complex. This is the idea of personality; that is to say, the reunion of presentations, the remembrance of all past impressions, the imagination of future phenomena. It is the notion of my body, of my capacities, of my name, of my social position, of the part I play in the world; it is an ensemble of moral, political, religious thoughts, etc.; it is a world of ideas, the most considerable, perhaps, that we can ever know, for we are far from having made the tour of the domain of personality. There are, then, in the "*I feel*" two things in presence of each other: a small, new psychological fact, a little flame lighting up,—"feel,"—and an enormous mass of thoughts already constituted into a system, "I." These two things mingle, combine; and to say "I feel" is to say that the already enormous personality has seized upon and absorbed that little, new sensation which has just been produced If we dared, and it is not so very absurd a thing, we should say that the "I" is a living animal, extremely voracious, a sort of amœba, which sends out tentacles to seize and absorb a very small creature—the small sensation which has just been born at its side.

This operation of *assimilation* and *synthesis* is repeated with every sensation which is born in us, and there are born in us every moment a quantity in the wake of all those thousand impressions which our senses incessantly receive. We may, then, represent to ourselves what is commonly called sensibility as a twofold operation. First, there is produced in the mind, in the cortical cells of the brain, if we may so speak, a very large number of small, elementary, psychological phenomena, the results of the innumerable external excitations. These are phenomena due to the tactile sense T T′ T″ (Fig. 2), to the muscular sense M M′ M″, to the visual sense V V′ V″, to the auditive sense A A′ A″, just to take these

as examples. You may call these phenomena what you like, *elementary sensations*, *affective states*,[1] to employ the expression of a celebrated French psychologist, M. Maine de Biran, or simply *subconscious* phenomena. The only thing which characterises them essentially is that they are simple psychological phenomena, isolated, without intervention of the idea of personality. Secondly, there takes place a reunion, a synthesis of all these elementary phenomena, which are combined among themselves and particularly combined with the vast and

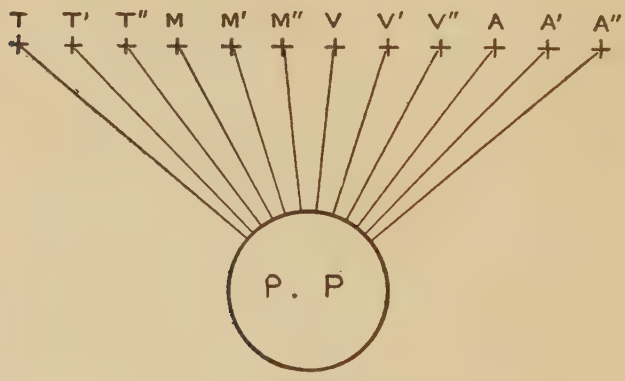

FIG. 2.

prior notion of personality. It is only after this sort of *assimilation* that we can truly say, "I feel." We formerly proposed to designate this new operation by the name of *personal perception*, P P; for it is indeed a perception—that is to say, a clearer and more complex consciousness; the word "*personal*" will prevent confounding this operation with the outward perception, of which we do not treat here, and will recall to mind that its essential character is the addition of the notion of personality.

[1] Maine de Biran, "Essai sur les fondements de la psychologie," *Œuvres inédites*, 1859, ii., pp. 11, 19.

The description and the schema which we have just studied are evidently theoretical, and can be applied to an ideal man only and not to a real man. No man, in fact, is capable of bringing thus together at each instant, in one and the same personal perception, all the elementary sensations which are born within him from all sides. With the best-constituted man there must exist a crowd of elementary sensations produced by the first operation which escape the second. These phenomena, such as T

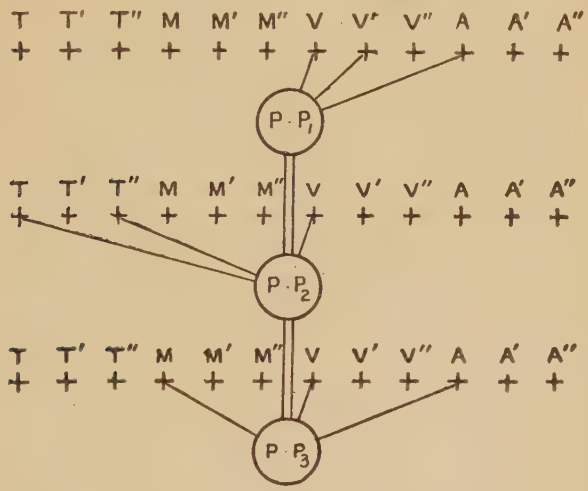

FIG. 3.

or M, in Fig. 3, remain what they are—namely, subconscious sensations, real, without doubt, and able to play a considerable rôle in the psychological life of the individual; but they are not transformed into personal perceptions and do not become a part of the personality. The person, the "I," will then say, "I feel," in regard to the phenomena V or A of which he takes hold and which he perceives, but he will not appreciate the existence of T or of M, and will say in regard to them, "I have not felt anything." What is the normal number of

phenomena, of elementary sensations which a man may thus gather into a personal perception? may be asked. We do not know, but we believe it very variable, according to a thousand circumstances, and we proposed [1] calling *extent of the field of consciousness*, the maximum number of such phenomena which an individual may, at a given moment, *assimilate*, and of which he may at that moment have *a personal perception*.

Let us suppose an individual who at each moment cannot perceive more than three elementary sensations, such as V V′ A, and who leaves all the rest in subconsciousness. There will then be in his mind, it would seem, a considerable void. Not, indeed, necessarily; for in the next instant he can easily, by directing his attention elsewhere, have the perception of those tactile sensations which he had left aside, and, in a third moment, he can form even a personal perception with muscular sensations, M. For instance, at the first moment, he will look at a person who is speaking to him and listen, without caring for the tactile sensations that continue to assail him. At the second moment, he will look at an object, touching it, and this time will appreciate the contact without being conscious of surrounding noises. At the third moment, he will write under dictation, having the perception of the sound of the voice, of the sight of the letters, and muscular movements. In a case of this kind, thanks to the alternating perception, there are no real anæsthesias. If we examine successively each sense,

[1] Sur la théorie du champ de la conscience, cf. *Autom. psych.*, p. 190, et sur son *rétrécissement*, p. 306. Ce dernier caractère du *rétrécissement du champ de la conscience*, est extremement important ; il ne se rencontre pas seulement dans les anesthésies, mais il fait partie intégrante de tous les autres symptomes de l'hystérie. Aussi est-il impossible de l'étudier complètement dans ce premier chapitre ; nous sommes obligés de rejeter cette question après l'examen des phenomènes particuliers. La description de ce rétrécissement de l'esprit et l'étude de l'épuisement qui semble le produire seront faîtes à la fin du second volume de cet ouvrage.

calling the subject's attention to it, we shall see that this person can have the perception of all the impressions.

This individual, although he may already have the field of consciousness contracted, is not an anæsthetic, but one absent-minded, and this study tries to represent what is called normal absent-mindedness.

Let us go a little farther, and we shall have the theoretical representation of anæsthesia. Suppose that *the field of*

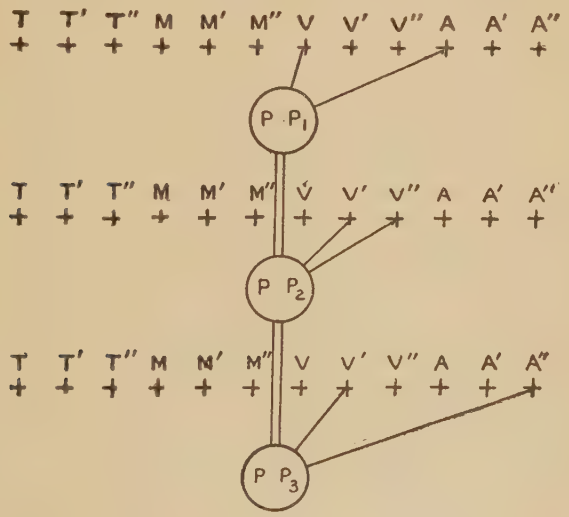

FIG. 4.

consciousness contracts still more. The patient (Fig. 4) can no longer perceive more than two elementary sensations at once. Out of necessity, even, he reserves this small share of perception for the sensations which seem to him, whether right or wrong, the most important, the sensations of sight and hearing. To have consciousness of what is seen and heard is of paramount necessity, and he neglects to perceive the tactile and muscular sensations, thinking he can do without them. At the outset, he might perhaps still turn to them and take them into his field of

personal perception, at least for a moment; but, the chance not presenting itself, *the bad psychological habit* is slowly formed. Nothing is more serious, more obstinate than these moral habits. There is a crowd of maladies that are only psychological tics. One day the patient—for he has truly become one now—is examined by the physician. He pinches his left arm and asks him if he feels it, and the patient, to his great surprise, is obliged to confess that he can no longer feel consciously. The too-long neglected sensations have escaped his personal perception; he has become anæsthetic.

Absent-mindedness, in a word, has been transformed into anæsthesia for two reasons: (1) because the habit the patient has contracted renders difficult the modifications of personal perception, which always tends in the same direction; (2) because the contraction of the field of consciousness is such that it does not need a strong and obsessing image to fill it, it being ever too small to perceive all sensations at once. Here, then, we have a new formula more precise than the foregoing. Anæsthesia is an extended and chronic absent-mindedness, which prevents those subject to it from connecting certain sensations with their personality; it is a contraction of the field of consciousness.

§ 4—EXPERIMENTAL AND CLINICAL VERIFICATION

The foregoing exposition of the psychological anæsthesia of hystericals rests on two principal notions: (1) the conception of the elementary sensations, real from a psychological standpoint, but not connected with the personal consciousness of the subject; (2) the conception of a weakness, of a particular indifference, on account of which the subject ceases to interest himself in his sensations and to perceive them. We have discussed these two questions at great length, in another work, from a phi-

losophical standpoint. Here it is sufficient to show their application to facts of observation:

Subconscious sensations.—It is always very difficult to demonstrate the existence of a psychological phenomenon in the mind of a person that is being examined. Consciousness is not visible outwardly, and the existence of such facts can be inferred only from their manifestations and consequences. The first and the most important of the signs which manifest the sensations are the outward movements dependent upon them. The simplest of these movements are the reflex acts; and it has been seen that, if we set aside for the moment certain special reflexes relating to pains or emotions, the sensory reflexes depending upon a precise sensation are all maintained. But most of these reflexes are considered, perhaps wrongly, as purely organic phenomena, having no relation with psychological facts. We must look for more complex movements, which can be explained only by the existence of a real sensation. We think that the postures called cataleptic attitudes, which are often so pronounced in anæsthetic members, might furnish good examples. When we raise Lucy's or Margaret's anæsthetic arm without her seeing it, and when we see this arm maintain exactly the complex attitude which we gave it, we cannot help thinking that there is in her, without her knowing it, a very precise sensation of the position given to the arm, and that this *Kinæsthetic* sensation is alone capable of co-ordinating exactly all the muscular contractions necessary to maintain that attitude.[1] This catalepsy of the anæsthetic members is very often produced only in well-determined conditions. With Léonie, as with many others, this phenomenon is not produced by all operators promiscuously, as one would say. If a person unknown to the patient should

[1] Sur l'existence des sensations pendant les attitudes cataleptiques, cf. *Autom. psych.*, pp. 55, 224.

raise her insensible hand in the same way, the arm would fall back flaccid. If, on the contrary, we took hold of that arm without the subject's being able to perceive by sight that it was we and not another, the arm would remain suspended as we intended it should. This is due to an electivity in the subconscious movements of which we shall speak later on. It will be necessary to remark here only that it is absolutely impossible to explain it otherwise than by supposing a contact sensation, delicate undoubtedly, but not extraordinary, by which the touch of my hand was distinguished and recognised.[1]

But we can go still farther: We place in the anæsthetic hand of one of the subjects—Bertha, for instance—an object without telling her of it, and without her being able to see it. The hand clutches the object, holds it tight so as not to let it fall. Some of the patients go no farther, and this is already something. But many others, like Bertha, modify the movements of the insensible hand according to the nature of the object. Bertha holds a pair of scissors placed in her hand, puts her fingers through the rounds, opens and closes the scissors alternately. We put into her hand a smaller object, a needle; she holds it and makes mechanical motions, as of sewing. Is it by chance that these precise movements agree with the nature of the object ?

Finally, in rarer cases, which it is impossible to analyse completely now, the anæsthetic hand, holding a pencil, starts to write. It is the automatic writing, analogous to that of the spiritualistic mediums, upon which we have already insisted. We have but to observe now that this writing expresses sometimes the knowledge of the sensations called forth from the anæsthetic member.

[1] For the study of similar cases, cf. "Anesth. et dissoc.," *Revue philosophique*, 1887, i., p. 461, and "Actes inconscients," *Revue philosophique*, 1888, i., p. 246.

We can, in fact, often, by processes which shall be indicated later, put questions which this writing will answer. If, for instance, we question as follows: "What are we doing?" We shall have for answer by writing: "You pinch me."—"What finger are we touching?" "The little one, the second."—"What are we putting into your hand?" "A little pencil—a cent."—"Where do you keep your left arm?" "It is raised; you have extended it," etc.[1] We can equally prove by this writing the existence of similar sensations regarding taste, smell, the anæsthetic part of the visual field. If the word is for us the characteristic sign for sensation in others, why should not writing be so, too? Can we admit that all these movements, more and more complex, are produced without there being any sensation?

Sensations are also and even very often the starting-point of what is called in psychology *associations of ideas*. When, through synthetic work, about which we shall have more to say, a certain union has been established between two psychological phenomena, the presence of one is enough to cause the other to start in the mind also. The one becomes, as it were, the signal for the other to appear. This law, in the study of hystericals, has given place to interesting experiments called *suggestions à point de repère*,—suggestions of marked points.[2] You may say to the subject: "Every time I pinch you, you shall raise your arm, or you will see a flower before you." We know that, with patients strongly suggestible, things will happen thus very regularly and that at each sensation of pinching they will suddenly raise their arm or will be surprised to see a flower appear. We tried to apply this well-known principle to the study of anæsthesia, by giving this kind of suggestion to the subject, but we placed the *point de repère* on the anæsthetic

[1] "Anesthésie et dissociation," *Revue philosophique*, 1887, i., p. 460.

[2] Binet et Féré, *Magnétisme animal*, 1887, p. 166.

member.[1] One may complicate things in various ways; the simple formula is the following: "When I pinch your *left* arm, you will raise your right arm." Most subjects whom we studied responded very regularly to a suggestion of this kind, even when they could not see that their left hand was touched. We told Bertha, during a somnambulic state, that at the moment when we should touch her thumb, she would see a butterfly before her, and that at the moment when we should touch her little finger, she would see a bluebird. When she wakes, one or the other of these two hallucinations will occur regularly as we touch her thumb or the little finger of her left hand. In the same way we say to Isabella, who is blind in the left eye: "When we show you a blue colour, you will hear the bells ring." Let us close her eye well and show to her blind left eye coloured worsteds. At the first colours she says nothing, except that she is in utter darkness, but as soon as a blue specimen passes before her eye, she exclaims: "Oh! I hear the bells ring."

This sort of experiment, which is very interesting and very demonstrative, presents a great difficulty. We must begin by bringing together in the mind of the subject the two phenomena; we must oblige him to make once at least the synthesis of the pinching and of the movement or of the hallucination. The experiment succeeds quite well if you have at your disposal some somnambulic state or other in which the subject may for a moment recover his sensibilities. The suggestion must be made when in that state. Later on, the association being organised, the pinching will bring with it the hallucination, even after the return of the anæsthesia. When a state of this sort cannot be obtained, the suggestion is more difficult, although it may still succeed. However, it often fails. For this reason it is very interesting to make use, for this experiment, of old associa-

[1] *Autom. psych.*, p. 434.

tions already organised in the mind of the subject before his disease. Now, there exists, as M. Binet has shown,[1] a natural and very frequent association between certain tactile and muscular sensations of our members and visual images. If we try to touch an object in the dark we convince ourselves that we have not only tactile sensation in the mind, but also that we think we see before us the form our hand takes and the object it holds. Now, this association exists with the hystericals as with ourselves; and we ascertain that it takes place even when anæsthesia has deprived them of the personal perception of the tactile sensations. Some, for example, know what movements are being impressed on their anæsthetic members. "I do not feel, but I think I see my arm before me in such or such a position." Justine, anæsthetic on her right side, can write, though rather badly, with her eyes closed. "I see," she says, "my hand that is writing." The visual image is here, as in the preceding hallucinations, determined by the association pre-established with the tactile sensation; but in order that this mechanism may work, the tactile sensation must be real, in some sort.

Finally, sensations manifest themselves also in *remembrances*, and we may again use this new manifestation to show the existence of sensations upon anæsthetic regions.[2] Here is an experiment of this kind made on Margaret, who has completely lost on her right side all tactile and muscular sensibility; she is so completely anæsthetic that she is unable to make any voluntary movement with her right arm when she does not look at it. To study muscular sensations M. Jean Charcot, house physician of the hospital,[3] has constructed a small

[1] Binet, "Sur les altérations de la conscience chez les hystériques," *Revue philosophique*, 1889, i., p. 162.

[2] *Autom. psych.*, p. 295.

[3] J. B. Charcot, "Sur un appareil destiné à evoquer les images motrices graphiques," *Progrès médical*, June 18, 1892, p. 478.

instrument which can be employed here. It is first of all a long stem, suspended Cardan fashion, and movable in every direction. The subject holds the stem by the middle as he would hold a penholder, and after having caused him to look away, we take hold of this same stem by the lower part, and follow with its point a word written on paper. The hand of the subject, if it is sensitive, will feel all the delicate movements in writing this word; the apparatus has enabled us to cause him to feel all those little delicate sensations and to retain, so to say, the graphic in the word we have written. But Margaret tells us that she has felt nothing at all. We know what that means: she has not had any personal perception of anything; has she had any elementary sensation ? In order to verify it, we put a pencil in her right hand, which is entirely insensible, and make her look away. We see her fingers take hold of the pencil and the hand write. How could this delicate movement take place, when but a moment ago the subject could not move without looking? This phenomenon cannot be studied now; it is enough to establish results. The hand wrote the name John, which was the same word with the same form of letters we wrote ourselves. Is not this a good proof of the persistency of remembrance, and does not this remembrance itself show that the muscular sensation was really there ?

This remembrance may reappear in another mode. It is sometimes enough to suggest to the subject to remember, to oblige him to pay great attention to the impressions he receives, to cause him sometimes to find again the remembrance of those sensations which he had not consciously experienced. This is one of the points which M. Onanoff, whose sad death we regret, has brought to light in a work on unconscious perception.[1] When remem-

[1] Onanoff, " La perception inconsciente," *Archives de neurologie*, 1890, p. 373.

brance cannot be recovered by this process, which happens frequently, we can put the subject to sleep, put him into one of those states where, as we have demonstrated, anæsthesia disappears. The return of sensibility brings with it the return of memory, and not only does the subject actually feel what is put into his hand, but he remembers what had been put into it when he was awake at a moment when he was seemingly anæsthetic. It is useless to continue enumerating these experiments, which can be varied indefinitely, but which always return to one of the three preceding types. Let us conclude on the first point with M. Herzen: "An idea that disappears from the consciousness does not, therefore, cease to exist; it may continue to act in a latent state, so to speak, below the horizon of consciousness . . . in this subconscious state, it may still have motor effects and exercise its influence on other ideas."[1]

To study now the manner in which the subject leaves aside these perfectly real sensations, we must make a few remarks upon the development of hysteria. This disease is not always the same at all moments, nor at all ages, and the hysteria of a little girl of twelve is not that of a woman of forty. We think we may distinguish three forms in the disease, the distinction of which will be made more and more manifest in this work: (1) *hysteria in a formative state;* (2) *hysteria in evolution;* (3) *hysteria established.*

1. To study *hysteria in formation*, we have applied ourselves, especially this year while in Professor Charcot's service, to the very young patients at the outset of their disease. We have observed in them mental troubles which shall be successively set forth. The question here is only of sensation. The patients, in the beginning, have no anæsthesia; this has been observed by all authors.[2] It is always easy enough, by successively calling

[1] Herzen, *Le cerveau et l'activité cérébrale*, 1887, p. 201.

[2] Gilles de la Tourette, *op. cit.*, p. 204.

their attention to each of their senses, to make them consciously experience all the sensations; but we establish a remarkable indifference and absent-mindedness to all phenomena of sensibility. They can distinguish only strong or strange or very agreeable impressions, as if these impressions produced a sensation of a particular sort, unexpected, which attracts their attention. Sometimes they seem at first insensible; then, if you renew the impression and insist on questioning, they perceive what you are doing to them. They are especially at some trouble in distinguishing two simultaneous sensations, and if you pinch their two sides at once, they feel only one sensation, generally on the right side. The absent-mindedness as to sensations, with the characteristics that we have indicated, precedes anæsthesia.

2. *Hysteria in evolution.*—This is the name we give to the malady in its period of activity, as it is when seen among most hospital patients, generally from the ages of eighteen to twenty-five, and sometimes even later. We say that the malady is in its evolution because it is shifting, and becomes transformed by suggestion, by emotion, and by imitation. The anæsthesias have become very clear; but their localisation shows that they are derived from the foregoing period. The hystericals lose rarely and only partially the sense of hearing; because it is indispensable in the social life, which they do not wish to renounce. They rather lose the visual sense, but never entirely. We have never seen a total hysterical blindness to persist more than a few hours after the attack; the fact may possibly exist, but it is a rare one. If hysterical anæsthesia were due to an ordinary lesion, why would it not more generally affect both eyes? On the contrary, if it is due to an absent-mindedness arising from a growing weakness of personal perception, it is plain that these patients always retain something of that indispensable visual sensation without

which life is so unhappy. The hystericals would rather lose tactile sensibility, because it is the least important—not psychologically but practically. At the outset of life, the tactile sense serves to acquire almost all ideas; but later, thanks to the acquired perceptions, the other senses nearly always supplant it. These persons lose sensibility on the left side rather than on the right side, probably because they use that side the least. We think we noticed that there are parts of the body—the finger-ends, the lips—in which they retain sensibility longer than in others, probably because the sensations derived therefrom are particularly useful or agreeable. Other sensations—those, for instance, derived from the articulations—are also preserved because they serve for the voluntary movements. It is true that if we consider the disseminated spots of anæsthesias which certain subjects have over their skin, we do not sufficiently know the variations of the local sensations, their resemblances, and their differences, the thousand influences that intervene, to understand the reason of these curious localisations. A thousand circumstances, in fact—examples, certain habits, suggestions, medical investigations even—may have the greatest influence in fixing here or there the localisation of anæsthesia. The phenomenon of insensibility in its ensemble is far from depending on suggestion, but its localisation sometimes depends on it.

What is particularly characteristic is the facts, already pointed out, of instability and the partial disappearance of anæsthesia. Not only does the sensation unconsciously persist, as has been seen, but it may momentarily become again conscious, either by an excitation which enlarges the field of consciousness, or because the attention is strongly turned to that side. If we put glasses, prisms, before the anæsthetic eye, if we provoke strange visual sensations, we can oblige the patient to become conscious of them. Finally, the sensations of

these anæsthetic parts may return to consciousness if, for some reason or other, they are strongly associated with other sensations which the subject may still experience. Oblige them to think of a visual image generally connected with a tactile image; tell Marie that a caterpillar is crawling over her arm, and the whole arm recovers sensibility. The fact is especially clear in that truly curious case of unilateral amaurosis which, indeed, deserves the interest that attaches to it. If we are at the right of Marie and speak to her, the persons that approach on the left are not seen, and she remains truly amaurotic in her left eye, even in the binocular vision; but if we cross quietly to her left, continuing to attract her attention, she continues to see us with the left eye. The visual sensations begun on the right have attracted, if we may so say, into the field of consciousness the sensations of the left eye. An experiment of M. Pitres, which he has repeated, is very instructive on this point: "Let us perform now," he says, "the experiment of the screen. I write on the blackboard a row of letters; a strip of pasteboard is placed vertically before the middle of her face and she is seated in front of the blackboard. With her left eye closed, she reads without hesitation the letters placed to the right of the screen. With both eyes open, she reads all the letters, those at the left of the screen as well as those on the right." [1] This experiment succeeds especially well, we think, if the letters written on the board form by their ensemble one single word. Small as may be the power of these patients' personal perception, however persistent their habit of neglecting the sensations of the left eye, they cannot well stop at the middle of a word, when the next sensation, which is quite real in their mind, forms the complete word. The sensations of the right eye, which are maintained as useful and indispensable in the centre of their small field of percep-

[1] Pitres, *op. cit.*, p. 58.

tion, bring with them images furnished by the left eye, as soon as there is some kind of reason to take them back again, as the image of the caterpillar on the arm brought back the latter's tactile sense. But if there be not in the restricted field of perception any evocative image, if the right eye be closed, or even if it looks at an object so disposed as to be seen entire by one eye alone, then the sensations furnished by the left eye, too long neglected by perception, are not taken back again.[1] M. Parinaud was, therefore, right when he said that there is a special mechanism for the binocular vision. There are functional associations, answering probably to anatomical localisations, which modify hysterical anæsthesia. But these modifications are possible only because all these anæsthesias were but complex forms of absent-mindedness.

3. Let us just point out here, to return to it later, *established hysteria*. The mental state of the hysterical, all upset and much reduced by disease, has become definitively reorganised on a particular type. All symptoms, or only a few, have now become fixed. There are habits which become a second nature and which we cannot change in a few moments by the feeble means which we may employ. The anæsthesias are then regular; they hardly ever disappear, and above all they are no longer modified by the transitory and feeble effects of attention. With these patients we shall not always be able easily to repeat the preceding experiments. They might succeed if, formerly, during the period of mobility, analogous phenomena had already been produced—if the tactile sensations of the left side had already been associated with movements or images. If no such association exists, we

[1] The study of certain cases of hysterical diplopia, which shall be made later in the second volume of this work, will perhaps show us a little better how this negligence of the sensations furnished by one eye, and which causes gradually the unilateral amaurosis, takes place.

shall not be able to bring it to pass at the present day, so that these anæsthesias must sometimes appear absolute.

Shall we say that these patients are entirely different from the others, and that their anæsthesia has become similar to the organic anæsthesia? Perhaps, in some cases, sensations which are never perceived, which cease being utilised, may disappear completely and give place to those serious anæthesias M. Onanoff speaks of.[1] We confess that we doubt somewhat the reality of this supposition. This old anæsthesia has gone through the preceding forms; it has preserved very specific characteristics—its intelligent localisation, the complete indifference with which the subject bears it, the preservation of the reflexes, etc. We should think rather that, in the practice of daily life, this anæsthesia moves along like its predecessors, only that it is less modifiable by our experimental processes.

The conclusion will then remain the same, despite this difficulty, and the proposed formula seems to have been justified in its two principal parts. Hysterical anæsthesia does not appear to be an organic malady. We understand by this word only a malady of the terminals of the nerves, or of the lower nerve-centres; it is a mental malady, a psychological malady; it does not exist in the members, nor in the cord, nor in the centres in the medulla, but in the mind. You will understand, once for all, that the word "mind" represents the highest functions of the brain and probably the functions of the cortex. It is out of respect for the scientific method that we employ the word "mind," and that we do not permit ourselves metaphysical speculations on the unknown alterations of the cerebral cells. In the mind itself this disease points to quite a particular phenomenon; it is but rarely an alteration of the elementary sensations, which remain what they should be, and which retain all their properties. It

[1] Onanoff, "Perceptions inconscientes," *Arch. de neurol.*, 1890, p. 377.

bears on a very special operation—on personal perception, namely, which permits us at every moment of our lives to connect between them, and to add to the notion of personality new sensations. It is due to a weakness of this synthesis of the psychological elements, which weakness we formerly called psychological disaggregation. (Hysterical anæsthesia is a malady of the personality.)

§ 5—SOME PARTICULAR ANÆSTHESIAS

In studying the general characteristics of hysterical anæsthesia, we have been obliged to pass over a few important details relative to such or such particular insensibility. It is impossible to forget them entirely, for some of them have become the starting-point of very embarrassing phenomena. Let us review the different senses, making, concerning each, certain necessary remarks.

1. *Analgesia.*—Insensibility to pain appears very early; it is very frequent and very deep-seated. What stops us here is that it appears to contradict completely the general theories that have been presented. Not only do the patients maintain that they feel no pain when pricked, or burned, but they do not make even the ordinary manifestations of a subconscious sensation. They do not react; they have none of those sudden starts which even subconscious pain should cause. It is true that M. Binet has sometimes noted some of those starts caused by a pain which the subject pretended not to feel; he has also known the subject to have a disagreeable emotion as if physical pain had changed into moral pain.[1] But this is very vague, to our mind, and very rare.

An observation noted by M. Jules Janet on Witm. shows that these subconscious sensations of pain play a very small rôle. Witm., with her feet absolutely

[1] Binet, "Altérations de la conscience chez les hystériques," *Revue philosophique*, 1889, i., p. 162.

anæsthetic, puts them when in bed on a bottle of water all too hot, and the next day the soles of her feet show big burns. This observation seems to show that pain had not existed even subconsciously. This patient may be put into a complete state of somnambulism, in which she recovers not only all her sensations, but also, as has been stated, the remembrance of the subconscious sensations of the waking hours. In this state she is asked: "Did you feel much pain in your feet while they burned?" "Why, yes," she said.—"Why did you not then move them away from the bottle?" "I don't know." We are disposed to believe that the patient, recovering her sensibility in a more complete state, imagined she had felt the pain. In any case, this phenomenon of suffering subconsciously must have been slight, since it could not induce her to move her limbs away from the cause of the pain, while slight tactile sensations, even subconscious, bring about with her complex movements. What makes this observation particularly curious is, that Witm. can present very clear examples of the subconscious persistency of all the other sensations, notwithstanding anæsthesia. All the experiments which we have described upon touch, the muscular sense, the sight, the hearing, etc., repeated on this patient, give unquestionable results. Pain seems to depart, more or less completely, from the general rule; we must recognise that. This difference between the sensations of pain and tactile sensations, provoked on anæsthetic parts, we once brought out by a rather curious experiment. M.'s anæsthesia is quite complete; it has reached even the ocular conjunctiva. We suggest to her during somnambulism: "When we touch the eye, you shall raise the right arm." When she wakes we pass over her face a piece of paper, and, at a certain moment she has not anticipated, cause this paper to touch the eye without its passing beyond the cornea, so that it is invisible. Immediately her right

arm rises, but the eyelid does not close. The suggested movement in relation to the tactile sensation was correctly executed, but the reflex movement in relation to the pain was not manifested.

We should take note of this important phenomenon. While most reflexes depending on determinate sensations, touch or sight, for instance, are maintained, most sensitive reflexes depending on pain are often very much reduced. In the eye, the pupillary reflexes are maintained; the palpebral reflex may disappear. In the pharynx, the reflex of deglutition remains, but not the reflex of nausea; the knee-jerk is maintained in the anæsthetic legs, but the reflex of tickling at the sole of the feet is suppressed. In short, and above all, the reflexes which depend on the fatigue of the members become reduced so much as finally to disappear. The anæsthetic arm, if raised, may remain in that position a long time, not only without any apparent suffering on the part of the subject, but even without respiratory troubles. In a word, whether from the standpoint of subconscious manifestations, or from that of the reflexes, the pain does not act as the other sensations[1] do. The conclusion is very simple: it is that pain is not a sensation like any other. Clinical facts confirm very often the opinions maintained by philosophers. Pain is not a simple phenomenon, to be kept isolated, able to exist alone, as a sensation of touch or colour; it is an already complex state of consciousness, a sort of emotion. "We estimate the intensity of a pain," said M. Bergson, "according to the interest the greater or lesser part of the organism takes in it."[2] And if, as is the case with hystericals, each phenomenon

[1] Same reflexion in a recent work of Fr. W. Myers, "Subliminal Consciousness," *Proceedings of the Society for Psychical Research*, 1892, p. 323.

[2] Bergson, *Essai sur les données immédiates de la conscience*, 1889, p. 27; see also Binet, "Contribution à l'étude de la douleur chez les hystériques," *Revue philosophique*, 1889, ii., p. 169.

remains almost isolated, without an interest in it on the part of the physical and moral organism, there is no emotion, no pain, properly so called. Analgesia then becomes connected with the preceding conception, the lack of synthesis, namely, of the psychological elements. Pain does not remain isolated, like other sensations, but disappears with the synthesis.

2. *Organic anæsthesia.*—We give this name to the loss of those vague sensations that are constantly informing us of the presence and life of our organs. Some patients not only cease feeling the touch of their limbs, but lose the consciousness of their existence. "It seems to me," a patient may say, "that my arm has been cut off at the shoulder." The most curious case we have met is Corn's: She had retained some sensibility in the thighs and at the end of her feet, but had no feeling in the legs. "I am strangely shortened," she said; "they have glued my toes to the end of my knees." Sometimes the phenomenon is more complicated; a patient of Professor Charcot's complained that her limb was both "painful and absent."[1] Another took her arm as if it were that of some other person.[2] Various illusions become thus superadded to anæsthesia. This kind of anæsthesia is very rare. We have seen only two examples of it and could not satisfy ourselves whether it left subconscious sensations after it. As to the conditions of its production, we have made a remark analogous to that of M. Pitres.[3] This anæsthesia does not last long; it disappears without there being observed in the other sensibilities other simultaneous modifications. Thus Corn's right arm was ordinarily sensitive; but, in consequence of small crises which took place during the night, her right arm

[1] Charcot, *Mal. du syst. nerv.*, iii., pp. 376–458.

[2] William James, *Proceedings of the American Society for Psychical Research*, i., p. 549.

[3] Pitres, *op. cit.*, i., p. 121.

suddenly became completely anæsthetic and paralytic. She said the next morning that her arm had been cut off at the shoulder. After a few days that illusion vanished and she could account for the existence of her arm, although we could not see any appreciable modification in either her anæsthesia or paralysis. This illusion, which seems to be the inversion of that of the well-known illusion of amputated limbs, does then take place, if we judge from this case, when there is a too-rapid modification in the sensitiveness of a limb, and disappears as soon as the subject becomes accustomed to it—that is, when the personality has learned to live with this anæsthetic limb.

We know that other organic sensations—those of hunger, thirst, the desire to urinate, etc.—may be wholly lost. M. remains several days without eating or drinking, and she does not experience the least inconvenience. She at last makes up her mind to do both, from a sense of reason, for she is not anorexic, but years have gone by without her having experienced hunger or thirst. She has likewise lost the desire of defecation and micturition. Her urethra and bladder especially are completely insensible. When she is catheterised, her bladder may be emptied or filled with two hundred grammes of borated water without her distinguishing the one process from the other. The anæsthesia of her bladder was so profound that she did not notice a cystitis which had developed in consequence of unclean catheters used by herself. On the other hand, during the somnambulic sleep, the cystitis took up again its classic character of painful cystitis, and the patient shrieked with pain.

M. Raymond thus describes the urethral anæsthesia of one of his patients: "You can thrust into the urethra to the very neck of the bladder a metallic probe connected with one of the poles of the electric battery, the other electrode being applied to the glans or to the perineum,

and make the maximum current pass through, without the patient's manifesting any sensation; it is the same with the rectum." [1]

These organic anæsthesias are generally accompanied with numerous disturbances of the functions of the organs. When the anæsthesia of the bladder and the urethra is complete, and affects the muscular as well as the tactile sense, we may establish diurnal or nocturnal incontinence at the least effort the patient makes.[2] This is, however, quite rare, and we would say that we have never seen an incontinence incontestably hysterical. What is much more frequent is the retention which, with M., always accompanies this anæsthesia.

We have not to study here these phenomena of paralysis and spasm. Moreover, we have not sufficient knowledge of the part psychological sensations play in all such organic phenomena clearly to understand these anæsthesias. Let us simply remember that in one point they resemble analgesia: they do not allow the existence of subconscious sensations. It is probably to this absence that we may attribute most of the serious troubles.

3. *Genital anæsthesia.*—Genital sensations are almost always preserved despite the general cutaneous anæsthesia; it is due to the importance the subject generally attaches to them. However, they may have disappeared, and certain hystericals are absolutely cold, despite the singular prejudice sometimes entertained against them. This anæsthesia, painful when it exists, is sometimes accompanied with most singular moral phenomena. We shall see, in speaking of the emotions, how a woman lost, at the same time, the sexual sense, the sense of shame, and even marital and maternal feelings. In fine, we

[1] Raymond, "Anesthésie cutanée," *Revue de médecine*, 1891, p. 395.

[2] Féré, *Archives de neurologie*, 1884; Jules Janet, "Les troubles psychopathiques de la miction, 1890, et les troubles vésicaux névropathiques," *Traité de chirurgie*, 1892, t. vii., p. 724.

know that this anæsthesia allows all reflexes to stay, and does not in general modify the functions of the erectile organs.[1]

4. *Kinæsthetic anæsthesia.* — The sensations which the movements of our members occasion us are most complex. We must, above all, avoid confounding the psychological phenomena which accompany the active movements made by the subject himself and those which are related with the passive movements communicated to the members from without. We speak here only of the second. Among these latter, the loss of the feeling of muscular fatigue has already been pointed out. It acts the same as an analgesia. This loss is quite frequent, and plays a great rôle in the phenomenon of cataleptic attitudes. The hysterical may also lose simultaneously or separately the sensation of pressure, of torsion or traction of muscles; in fine, what is more special, he may lose the notion of the unequal contractions of the different muscles.[2] The result is that he is incapable of appreciating the weight of objects, even when he tries to lift them[3]; that he does not know what movements he should cause his limbs to make; in short, that he is not aware, without looking, of the position he has given to his limbs. According to a celebrated expression, often true, he loses his legs in his bed. To appreciate this muscular anæsthesia, it is enough, when it is deep-seated, to move the subject's head away and displace his arm, asking him either to describe the position of the arm or, what is still better, to place voluntarily his other arm in a similar attitude. When the muscular anæsthesia is not complete, it is more difficult to appreciate it. We may then apply to this investigation an experiment, already

[1] Briquet, *Hyst.*, p. 472.

[2] Duchenne (de Boulogne), *Electrisation localisée*, 1855, p. 410.

[3] Gley et Marillier, "Expériences sur le sens musculaire," *Revue philosophique*, 1887, i., p. 441.

old, of M. Beaunis.[1] The author had made use of his method for studies of subjective psychology. He made the movements himself and tested his own sensations. We have often tried to apply his process in an objective way. You put a pencil into the subject's hands; then, while he turns his head away, you guide his hand so as to trace on the paper a line of a fixed length, two dots separated by a few centimeters, or an angle of a prescribed opening. This done, without allowing the subject to look, you tell him to begin again and to make a similar line for himself, two dots separated by a similar distance, or an angle of the same degree. You then compare the two drawings, and in some cases you may reach some conclusions concerning the kinæsthetic sensation of the subject. Some inconvenience in the experiment may, as we have shown,[2] be avoided, if M. Jean Charcot's instrument, described in a preceding paragraph, be used.

In all these investigations we must take care that the subject makes always the required movements consciously and voluntarily, for the subconscious kinæsthetic sensations are here very frequent and clear. Their existence has often been noted in the preceding experiments. We cannot dwell any longer here on the study of kinæsthetic anæsthesias. These anæsthesias are interesting only in their relation to movement, which will be the subject of a special chapter.

5. *Tactile anæsthesia.*—We know that several different phenomena are often united and confounded under the name, sense of touch. Hysteria often effects interesting dissociations by effacing such or such particular sensitiveness, while it allows others to exist. Analgesia or loss of

[1] Beaunis, "Communic. à la soc. de psychol. physiol., sur la mémoire des sensations musculaires," *Revue philosophique*, 1888, i., p. 568.

[2] "Note sur un appareil destiné à l'étude experimentale des sensations kinesthésiques," *Revue philosophique*, 1892, ii.

the sense of pain exists frequently, while the touch, properly so called, is somewhat maintained. Sensitiveness to heat or cold may exist alone, while pain and touch have disappeared. Inversely, again, the subject may feel, as by simple slight contact, the impression of a burning or freezing object. The latter case simulates, as we see, the syringomyelia dissociation.[1] Finally, all these special sensibilities may be simultaneously lost, and the subject, consciously at least, distinguishes none of the impressions made upon his insensible hand. When the anæsthesia is deep-seated, it is enough, in order to establish it, to prick the subject, to put something into his hand and to ask him if he feels anything, avoiding, of course, subconscious movements or answers. If the anæsthesia is incomplete and reduced to an hypoæsthesia, it is often difficult to describe it exactly. We think that the æsthesiometer, however imperfect it be, may render here some service, even from a clinical point of view. To use this instrument experimentally a part of the body should be chosen, always the same, of medium sensibility, the normal measure of which will be fixed; then, with this instrument applied to the body of the patient, on a corresponding place, it can be verified how much her sensibility varies from the normal. We once selected a place seemingly convenient—namely, the inner surface of the wrist. The normal sensibility on this spot appeared to be from twenty-five to thirty-five millimeters; when we ascertain on a patient, as it often happens, figures like ninety, a hundred and twenty, etc., we may, we think, without hesitation, consider her hypoæsthetic, and this may sometimes give precision to the diagnosis. We must not forget that often a characteristic of the hysterical's mind prevents the use of the æsthesiometer. Some of them, like M., are often incapable of appreciating two

[1] A. Souques, *Étude des syndromes hystériques "simulateurs" des maladies organiques de la moelle épinière*, 1891, p. 201.

sensations at once, but in this case the mental symptom is clear enough to make sure of the diagnosis.

We shall not speak of the subconscious sensations of the tactile sense, for they have found their place in the general description; but we shall insist on a very curious consequence of incomplete tactile anæsthesia—namely, the hypoæsthesia.

The localisation of the sensations, without summing up its theory, depends in great part on the precision and delicacy of the tactile sensations. Every spot, of the skin furnishes to the mind a special sensation, a particular shade proper to it on this particular spot, which is not exactly the same on another. Each sensation due to the excitation of one point of the body becomes thus a special sign, by which we have, by acquired association, the image of the corresponding part of the body. But if the sensations become vague, they are bad signs, which become confounded with each other and no longer call for the clear images of the small portion of the body impressed. Therefore, localisation is vague with all the hypoæsthetics who are incapable, for example, of putting their finger exactly on the spot which has been pricked, or who confound two sensations provoked on two neighbouring spots, as may be seen in the experiment with the æsthesiometer.

But amid these confusions there is one, more frequent than is thought, of which the study is particularly instructive. M., whose observation we communicated to the Society of Physiological Psychology,[1] is, in a general way, and has been for years, totally anæsthetic. Occasionally, after a prolonged state of somnambulic sleep in particular, she recovers for some time in her consciousness the tactile sensations, but always in a very incomplete way. Sometimes sensibility seems to reappear

[1] "Une altération de la faculté de localiser les sensations," *Société de psych. physiol.*, March 31, 1890; *Revue philosophique*, 1890, ii., p. 659.

under the vague form of pain- discomfort—without any very distinctive sign. The sensations are altogether indistinct: heat, cold, pinching, an object placed in the hand, —all this provokes only a vague sensation of something painful, without the subject's knowing what it is. As any rate, it is certain that at that moment there is no localisation, the subject absolutely not knowing where he is pricked, where touched. But it may happen that sensibility is, for some time at least, more complete. M. has feeling everywhere and distinguishes quite clearly various sensations; she recognises heat, cold, pinching, a sting, names the object put into her hand, etc. There is also a remarkable progress in the localisation of the sensations: "You are pricking me, touching me on the shoulder, arm, wrist, knee, ankle," she replies to me quite correctly. These sensations and localisations are painful, somewhat behind time in regard to reaction, but yet seem sufficiently satisfactory. Well, it is just on this curious point that we insist, notwithstanding this sensation and localisation. She cannot distinguish in any way the two sides of her body: "You prick my wrist," she says. "True, but which wrist; the right or the left?" "I do not know." If we insist too much, she answers at random and blunders nearly always. We request her to touch with her finger, without looking, the place of her body we are about to pinch. She feels the pinch and tries to touch the place; but she hesitates and looks for the side she is to touch. At last, she makes up her mind and touches at random either the spot on the chest which we had pinched, or the exactly corresponding spot of the other side.

This confusing of the two sides of the body exists also in regard to the muscular sense. She cannot tell which of the two, the right or the left arm, we have moved, although she well knows that it is the arm and not the leg. However, some few movements are

better distinguished. When she is told to make the motion of sewing some stuff, she distinguishes between her hands: " There is one," she says, " that does better than the other." Another patient of the same kind, Cath., would make the sign of the cross in order to distinguish her right hand from her left. Certain muscular sensations, not all, have, then, retained distinctive signs. Lastly, this confusion attaches even to visual sensations. M. has her eyes open; we take one of her hands and place it under her eyes: " Which hand is this, right or left ?" " I do not know; let me see if it has a ring on it, then it is the right." She recognises her hands only by this sign—the presence or absence of the ring. In a word, with a sensation apparently sufficient and a localisation exact enough regarding the vertical direction of the body, she is absolutely incapable of distinguishing between the corresponding parts of the body.

It is useless to seek a new name for this phenomenon; it can be designated by the one known, *allochiria*, for we believe that this confusing of the two sides of the body is closely connected with the phenomenon usually designated by this name. However, to distinguish it from the complete allochiria of which we speak presently, we propose to call M.'s state *simple allochiria*. How are these things to be represented ?

We thought at first that M.'s trouble was in not being able to distinguish her hands by sight and that we had here a visual disturbance. We doubt it now; when we look at our hand, using only the visual sense, we are in the situation of the student of anatomy who recognises a humerus, whether right or left. The student cannot do so except by putting the bone in position upon an imaginary subject whom he places before him and in comparing next the members of this subject with his own, which he already knows. It is this previous knowledge of our two sides through the tactile sense which allows

us to make this distinction through the visual sense. To sum up, we recognise our left hand by the sign that, being in the act of pronation, it has the thumb within and the little finger without. But if we did not distinguish our two sides, there would be no median line, no within, no without. It is this distinction by the tactile sense which is here fundamental, and it is its alteration with M. which brings with it the other phenomena.

What is difficult to understand is that the tactile sense did not seem to be affected in her at that moment. She quite recognised the objects put into her hand, and distinguished shades of sensations, since she did not confound a prick in the finger with a prick at the wrist. We are obliged to admit a psychological notion but little known, which is, however, we believe, very important in the pathology of hysteria. To be brief, let us call *symmetrical sensations* those which are produced by the excitation of the symmetrical points of the body. Two symmetrical sensations must be very difficult to distinguish—that is, almost alike. It must be more easy to distinguish a prick on the hand from a prick on the wrist than to distinguish a prick on the right wrist from a prick on the left wrist. Hysteria, which has taught us a great deal about the shades of sensations and about their associations, furnishes us, in addition, thanks to simple allochiria, the notion of the resemblance of the symmetrical sensations.

Things become unfortunately complicated; and at other times, with this same subject, M., and others, we can observe not only simple allochiria, but *complete allochiria.* M. is now a little more sensitive than formerly, and we expect her to localise better. In fact, she no longer hesitates; she feels the difference between her two sides, and she answers clearly. Yet she answers always wrong. We put a pen into her hand and tell her to mark on her body the points we are going to prick; she does not

hesitate, and marks always on the *opposite side* the point exactly symmetrical—on the right shoulder, if we have pricked the left, and on the left arm if we have pricked the right. This is not a suggestion. The fact is quite old, and M. Jules Janet had already noticed it in her years ago, without having this question in mind.[1] We were endeavouring, by increasing the sensibility, to do away with this confusion and not to aggravate it. There is here a singular psychological fact, which must intervene in many other disorders. We do not think that we can explain it. Here is the succession of phenomena by which we can try only to represent it. The two symmetrical sensations, D. and G., are very like each other. During the periods of hypoæsthesia they became confounded, and at this moment, as has been seen, there was no longer any distinction between the two sides of the body. There resulted from it an association between these sensations, such that the presence of D. brings to the mind the image of G., and reciprocally. The subject, more sensitive, could now distinguish the two, but, in consequence of the previous association, she does not have them simultaneously in the mind, but consecutively. By an illusion, we do not know what,—perhaps by that law which makes us give more importance to the final phenomenon of a series, and forget the sign when we hold the thing signified,—she forgets the first provocative sensation D; she does not perceive it in her field of consciousness; she seizes only upon the evoked image, G. This image being quite clear, she localises it well, but it corresponds only with the symmetrical point of the point excited.[2]

Some persons may, perhaps, be surprised that we insist

[1] *Autom. psych.*, p. 157.

[2] I regret not to be acquainted with the works that have been written on hysterical allochiria. I do not know if my observations and my hypothesis agree with those already made.

somewhat on this little fact; but they will see later, when we shall speak of motion, that it reappears in various circumstances and that it is indispensable to know it well to study a phenomenon which has much interested the observers—namely, that of transference.

6. *Anæsthesias of the special senses.*—We pass over the anæsthesias of taste, smell, hearing, whose characteristics

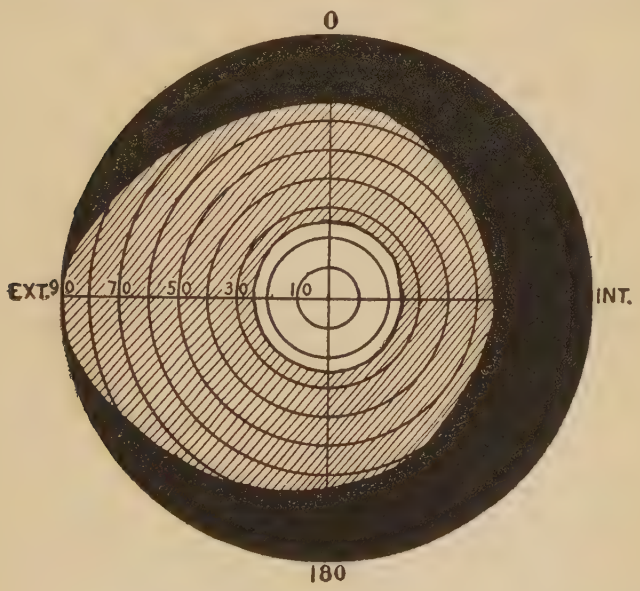

FIG. 5.

are known. The last is very rare and always unilateral.[1] It is also known that these anæsthesias allow incontestable subconscious phenomena to exist. Although Witm. has her left ear quite anæsthetic, and does not seem to hear anything when the right ear is stopped up, verbal suggestions may yet be made to her which will be very well executed without her knowing it.

7. *Anæsthesia of the visual sense.*—It is impossible to

[1] Pitres, *op. cit.*, i., p. 93.

examine here all the troubles of vision which have been the subject of great and well-known works. We wish to insist on a particular point only which has always greatly interested us—namely, the *contraction of the visual field.* The visual field is an ensemble, a system of sensations simultaneously perceived, which contracts in the same manner as the field of consciousness. The sensation which

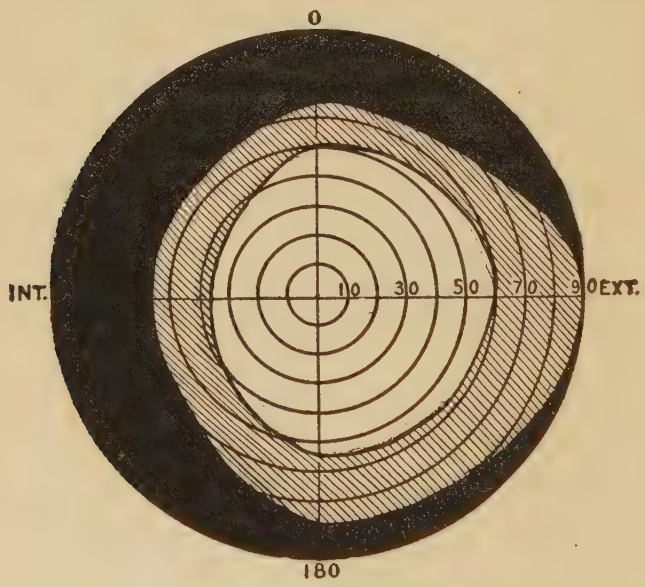

Fig. 6.

serves as centre, and around which the others are grouped, the one, namely, which always obtains the maximum of consciousness, is naturally, save in exceptional cases, the clearest visual sensation, the one which corresponds to the point of fixation. It is therefore natural that the visual field, contracted because of psychical causes, should take the circular form around this centre. This is regularly seen, in fact, in all very small visual fields (Fig. 5). When the field is not very much contracted,

we have noticed, I think, that it is regularly circular, but assumes, rather, a form almost concentric with the normal field, which is not circular either (Fig. 6). There are very few exceptions to these laws, and they should be studied carefully to see if they do not depend on some fixed idea, wholly accidental. M. Briquet pointed out as a somewhat common thing the hysterical hemianopsia, which appears to us somewhat strange.[1] M. Pitres admits the existence of the central scotoma and of lateral hemiopia in hysteria, not complicated, of course, with encephalic lesions.[2] M. Féré and other authors absolutely deny the existence of these forms in hysteria. We dare not take part in this quarrel, and we do not wish to doubt a phenomenon because it does not seem to agree with our psychological conceptions. We will say only that in a hundred patients, whose field of vision we have often examined under many different circumstances, we have never met with modifications of this sort.

If the visual field is generally concentric, it is *extremely variable* in its extent; it seems, in its widening and contraction, to follow all the modifications which the mind of the patient undergoes; it is, as it were, the barometer of hysteria for certain patients. Let us first point out a few circumstances that widen it. The somnambulic state, as we have already observed in speaking of other senses, increases it often to an enormous degree. Bertha passes from 5° to 90°, Maria from 40° to 80°, Margaret from 35° to 60°, Fernanda from 40° to 60°, etc.[3] This widening may persist if the somnambulism be prolonged, or diminished if we leave the subject alone without exciting her. Bertha, at the end of two hours' somnambulic sleep, fell from 90° to 60°. This widening persists

[1] Briquet, *op. cit.*, p. 294.

[2] Pitres, *op. cit.*, i., p. 98.

[3] A single figure employed to represent the visual field designates the greatest angle, the external angle.

sometimes after the somnambulic state. M. has but 9° before being asleep; she has 20° after being wakened. If we add to somnambulism the effect of suggestion, we can increase it still more. M., instead of 20°, will have for some time on awakening, 40°. Other physical or moral excitations have analogous effects: Cl. has but 20° in the left eye; if we allow her to get drunk on ether she will have 40°. M. Parinaud has seen that it often sufficed to cause the eye on the sound side to open, for the visual field of the amblyopic eye to increase at once from 10° to 20°.[1] The sensations of the sound eye bring into the personal perception, by a pre-established association, those of the neglected eye.

The influences which diminish the visual field are still more numerous. All physical depression has an influence on it. Maria, who shows generally 40°, shows 20° at the time of her menses. Eug. passes from 70° to 30° after two slight attacks, and from 70° to 40° after a sleepless night. Professor Charcot remarks that a patient, Porcz., whose visual field appeared at first normal, showed a contraction after an excursion in the course of which he grew tired.[2] It is the same with moral phenomena: fatigue, even in the course of an ocular examination, reduces the visual field and causes the physician to believe that the contraction is enormous.[3] D. has 55° if rapidly examined; she falls to 25° if you are ten minutes examining her. Preoccupations, emotions, and, above all, fixed ideas in the subject's mind, contract the visual field, and we have already said that Justine's and Maria's fixed ideas could be followed by simply examining their visual field.

A last phenomenon seems more important for psychology and deserves a longer analysis. We discussed

[1] Pitres, *op. cit.*, i., p. 104.
[2] Charcot, *Mal. du syst. nerv.*, iii., p. 324.
[3] Gilles de la Tourette, *op. cit.*, p. 336.

formerly with one of our first masters, M. Gibert, the diagnosis of hysteria in a patient whose somnambulism we were studying. We said to M. Gibert: "We have measured her visual field and it stands for each eye at 15°." "That is impossible," he replied to us, "for I have thoroughly examined it and found it almost normal." This contradiction surprised us very much, and we tried to account for the way in which it could have occurred. This is what we discovered: In order to examine rapidly the visual field of the patients we made use at that time of a portable perimeter invented by M. Azoulé, a simple wooden arc which we held up at the centre with our left hand. The subject, very often hypnotised by us, fixed her attention, in a sort of contemplation, upon our hand and had then a visual field of 15°. If we took a less rudimentary instrument, resting on a support, the subject looked at the central point with much less attention and had a visual field, not normal, indeed, but very much larger. We concluded from it that the nature of the point fixated by the subject and the degree of attention she paid to it played a part in the extent of the visual field.[1]

It is for this that we undertook a series of researches, conducted as follows: At the centre of the apparatus, on the central point, we fasten a piece of paper on which, according to the case, some sentences or numbers are written very small. We place the subject in the proper position to measure her visual field; we close one of her eyes and request her not only to look at the centre but also to read the paper, or mentally to make up a sum with the numbers written on the paper. When her attention is well fixed on the work, which usually takes a

[1] I have already communicated these facts to the physiological-psychological congress of 1889. I am happy to learn that one of my friends, M. Séglas, has since established them independently, not aware of this first communication.

little while, we draw the stick on which the small white object is fastened over the perimeter from the external side of the eye that is being examined, moving from the periphery to the centre. We stop a few moments at the point which we know to be within the subject's field, 40°, for example. At this moment we interrupt the subject in her work and ask her if she has seen the signal advancing on the arc. According to her answer, we begin the operation over again under the same conditions, leaving the signal farther off or bringing it nearer toward the centre. We succeed thus in determining the subject's visual field during the fixedness of her attention.

With many normal men these conditions do not modify the visual field; with some they diminish it from 5° to even 10°; but with hystericals and, in general, with patients whose attention is modified, this process brings with it surprising contractions. Margaret, whose visual field is 40°, has but 10°. Maria has a very variable visual field, but whatever it be, great or small, at the moment of the experiment, it becomes always contracted through attention; it passes from 80° to 20°, from 65° to 30°, from 30° to 15°. Justine has not usually, except when in a state of fixed ideas, any apparent contraction; in these new conditions she passes from 90° to 30°. Bertha has normally a visual field of 5°; but, by excitations, and, in particular, in the somnambulic state, the contraction disappears and the field is 90°. If, during these artificial states, you ask of her an effort of visual attention, she immediately turns back to her habitual small field of 5°. In a word, in a great number of cases, with these debilitated persons, the effort of visual attention contracts in a very notable way their visual field.

This statement is not without interest. From a clinical point of view, it furnishes an element of diagnosis and enables us to find again this great hysterical symp-

tom, the contraction of the visual field when it is concealing itself. With both Justine and Bertha, the visual field, in the cases indicated, appears normal; this artifice shows the contraction, which was in some sort latent. From a psychological standpoint, this is a little fact to be studied in order to understand the disturbances of attention and attention itself. It may be seen here that the phenomena of attention do not depend solely on movements, as has been said, for the modifications of the visual field cannot be connected with movements. We see how the power of personal perception cannot, when it is small, bear on one point without letting go the others. In short, it would perhaps be possible to establish here the effort of attention in order to synthetise phenomena. It is because there are more details to be perceived at the central point that the peripheral visual field diminishes.

Without insisting on these purely psychological questions, we are content with remarking that the studies on some particular forms of anæsthesia, and especially the study of the visual field, confirm our general conclusion. In all cases, even in the last, the sensations have not absolutely disappeared; they have become simply subconscious because they have left the field of consciousness.[1] The contraction of the visual field may be considered the sign of hysterical sensibility in general. Personal perception, the consciousness *we* have *ourselves* of the facts of consciousness, is less large; it succeeds no longer in bringing together the normal quantity of facts

[1] This conception of hysterical anæsthesia has already been confirmed by a certain number of interesting studies we are happy to point out. Besides the articles of M. Binet and of M. Onanoff, which have already been cited, we shall indicate the work of M. Max Dessoir, "Dasdoppel-Ich.," *Schriften der Gesellschaft f. exp. Psych. zu Berlin*, May, 1889; the book of MM. Paul Blocq and I. Onanoff, *Sémeiologie et diagnostique des mal. nerveuses*, 1892, p. 199, and the article of M. Paul Blocq, "Des stigmates hystériques," *Gazette des hôpitaux*, January 23, 1892.

ordinarily perceived. It is but a representation of phenomena; other studies will teach us, perhaps with a little more precision, whether this contraction of the field of consciousness depends on some fixed idea, or whether it should be considered as primitive, and connected with general exhaustion.

CHAPTER II

AMNESIAS

THE study of memory and its modifications is certainly one of the most important for pathological psychology as well as for normal psychology.[1] That a great number of the disorders of intelligence, activity, character, and even motion, are, in the end, troubles of memory, is a thing that may be considered as demonstrated. For hystericals in particular, the facts apparently most remote, such as their caprices, their suggestibility, and their paralyses, are, when closely investigated, due to the alterations of memory. A complete study of this function would explain a large number of the phenomena of insanity. Unfortunately, such a work is nowadays, if not impossible, certainly most difficult. If you but attempt logically to classify all amnesias, in what a labyrinth of facts and observations you will be lost! Memory is, in fact, one of the most complex functions of the mind, and each of its parts may be modified, and indirectly thereby change all the others. Thoroughly convinced of these difficulties, we shall not endeavour to enter into the details of amnesia as we have done in regard to anæsthesia. We shall be satisfied if we make, as much as possible, its principal facts comprehensible.

[1] This chapter contains, with a few additions, a lecture delivered at the Salpêtrière on March 17, 1892. *Archives de neurolgie*, July, 1892, ii., p. 29.

§ 1—DESCRIPTION AND CLASSIFICATION

To describe hysterical *amnesias*, it will be necessary, we think, to set forth as a prime consideration a characteristic which may be somewhat surprising. Amnesias occur *very frequently* and are met with, under various forms, almost as often as anæsthesias. M. Briquet had already noticed this: "the faculty of fixing the attention," he says, "is notably diminished. Memory, also, is weak and often null with hystericals. We have seen a patient with whom amnesia had reached a point where she could no longer calculate time. What had occurred the day before did not seem to her any nearer than what had taken place several years before. This diminution of memory is quite a common thing."[1] Professor Charcot has often insisted on the same thing. He observes that the amnesia of hystericals, victims of traumatism, "bear not only on things relative to the accident, but even on things present."[2] He also points out the errors of interpretation to which these losses of memory give rise.

This patient,— he says [referring to one under his charge], —has always been objected to in the hospitals as simulating; it is true that he often contradicts himself in what he has to say, and perhaps he lies sometimes; but we have to take account of a mental state still insufficiently studied, above all frequently to be found in virile hysteria, and where temporary amnesia holds a large place. There is, no doubt, both truth and error in what he says, but it is for the physician, as we told you the other day, to distinguish what is true, and not condemn a man from the first without thorough examination.[3]

[1] Briquet, *op. cit.*, p. 519.
[2] Charcot, *Mal. du syst. nerv.*, iii., p. 401.
[3] *Ibid.*, *Leçons du mardi à la Salpêtrière*, 1887, p. 297.

These remarks are easily verified every day. M. Gilles de la Tourette,[1] M. Souques, and many others note a particular difficulty met with in examinations of hystericals. Their accounts are constantly incomplete and contradictory. They relate the next day the observation that was taken down under their dictation the day before, very differently. You cannot trust their accounts to reconstruct the history of their life or of their illness.

A thousand noticeable details, when we watch their behaviour in the ward, bring us to the same conclusion. Many patients, on entering the Salpêtrière, weep and groan at the thought of leaving their relatives, to live alone at the hospital. The next day all is over; they have forgotten their regrets and they believe, they say, that they have been in the house for months. Some among them, because of their forgetfulness and continuous absent-mindedness, are altogether incapable of doing any work, of rendering any services. If you send them on an errand they come back after some hours without having accomplished anything, because they have forgotten why they went out. One of them one day got quite angry and reproached us with imaginary delinquencies in a more or less polite fashion. The next day we thought fit to show her some coldness. She was very much surprised and quite uneasy; came to ask us what we had against her. She had completely forgotten the scene of the day before. In a word, it is enough to question them at haphazard about their life at the hospital—their past life; ask them what they did the day before, in the morning; what they purposed doing in the afternoon, and you will certainly find a number that cannot answer. They live from day to day, scarcely able, as has been seen, quite to understand what is going on at the present moment, and generally powerless when the

[1] Gilles de la Tourette, *op. cit.*, p. 552.

remembrances of the past and the images of the future come into question.

This continuous forgetfulness must be well understood, for we could not otherwise comprehend the conduct of the patients. As Professor Charcot said, it is from that forgetfulness that arise, not always, but very often, the so-called lies of the hystericals. In the same way may also be explained their whims, their changes of temper, their ingratitude, their inconsistencies, in a word, for the connection of the past with the present, which gives gravity and unity to conduct, depends largely on memory. Finally, these remarks are important from a clinical standpoint; in fact, although it may perhaps appear strange, the cases of forgetfulness of the hystericals—numerous, variable, bearing on movements and on acts as well as on ideas—may simulate the most serious states of dementia, and the diagnosis may here be of primary importance.

In order to classify the troubles of memory which hystericals present, we must first set aside the congenital weaknesses of memory which they may present, but which do not belong to their malady. M. Sollier, who has very completely described many troubles of memory, and who has laboured to classify all these numerous varieties, takes up again an old expression and calls these enfeeblements or enervations dysmnesias.[1] Hysteria may attack persons of feeble intelligence, whose brain is congenitally or accidentally not capable of fixing remembrances. We shall not make any allusion to these alterations. Memory may also present delicate modifications bearing, not on the remembrance itself, but on the intellectual operations which are ordinarily superadded thereto. The localisation of the remembrances in particular may be very vague, while the remembrance is in reality preserved, and divers rather curious illusions may result

[1] Paul Sollier, *Les affaiblissements de la mémoire*, 1892, p. 10.

from this. These *paramnesias*, to employ M. Sollier's [1] expression, are frequent with hystericals. It is best to put them aside at the beginning of these researches and describe first amnesias, properly so called, where the loss of memory seems clearer and more complete.

These amnesias, in the first place, appear to form three great classes, analogous to those which have been adopted for anæsthesias. They are: *amnesias systematised*, *localised*, and *general*. But it will be necessary here to add a fourth category, that of the *continuous amnesias*, for a group of lesions of the memory, altogether special, which is separated from all the preceding ones. The first three forms are, as their names indicate, losses of remembrances, and, although this may appear rather naïve, we shall observe that a remembrance cannot be lost unless it has once existed; amnesias bear, then, on real remembrances, which the patient has possessed and which he has been able to manifest for a certain time. It will be seen that this very important characteristic is not found in the last class, which is, consequently, quite distinct from the others.

The first, *systematised amnesias*, are perhaps the most frequent. The patients lose, not all their remembrances acquired during a certain period, but a certain category of remembrances, a certain group of ideas of the same kind, constituting a system. Thus, they will forget what relates to their family or all the ideas relating to such or such a person. A woman, after confinement, will forget not only the birth of her child, but even the facts connected with it; she might likewise forget the name of her husband and even forget her marriage, while she will remember other facts quite foreign to the birth of her child. There was at the Salpêtrière a few months ago a young girl, called Celestine, very seriously ill with hysteria. As this patient interested us, we took care of

[1] Paul Sollier, *op. cit.*, p. 15.

her as soon as she came, and nearly every day, so that she became very intimate with us. One day, in passing, we said "Good morning" to her; she looked surprised, did not answer, but walked over to the lady superintendent to speak to her in whispers. Naturally, we asked the warden what was the matter with Celestine and what she had to say, pointing at us as she did: "Nothing," she replied; " there is nothing the matter with her; but she seems to become stupid. She came to ask me who you were, and wondered why a student newly come into the service should know her and call her by her first name." We attributed the remark to a spell of bad temper or to a joke; but, after having examined her, we understood. Celestine, the evening before, had a rather serious crisis which, as often happens, upset her mental condition, and she had completely forgotten us. Her memory, regarding the events which had happened during her stay at the hospital, was evidently very weak, yet she remembered pretty well the other persons; as for us, she had altogether forgotten every remembrance, and the facts connected therewith. This strange condition of her memory might have lasted some time, but we were curious to see if the hypnotic sleep had also changed in character, and we induced it. She did not exhibit the same trouble while in the somnambulic state, and remembered us as usual. When she awoke all was as it should be, and this singular systematised amnesia, following an attack, had disappeared.

Such forgetfulness often bears on the language. We do not mean the absolute loss of language, varieties of mutism—but the forgetting of certain words or certain categories of words. G., for example, presented, after a violent emotion, spontaneous somnambulisms at night, then great attacks of hysteria. What is interesting here is her forgetfulness, very systematic, which is easy to establish. She spent three years in England and spoke and

understood the English language quite readily; but, during these last months, since her malady became aggravated, she has so completely forgotten the English that she cannot understand nor speak a word of it. These losses of language may be still more special: Bertha forgets proper names, she confounds them at first, says one for another, then she loses them completely, and involuntarily calls everybody "Marie." Justine loses the motor memory of certain words; she hears them, but cannot pronounce them. Her husband is obliged to articulate them clearly before her so that she may see the movement of the lips and so try to reproduce them. When she is alone and wants to pronounce these words, she has to call up the visual image of her husband's lips and copy the movement. She forgets how to write, and all at once does not know any more how such or such a word is written, or perhaps she writes it with a fancy orthography, or simply passes it over. It is scarcely necessary to add that these lapses of memory observed in speech and writing might be attributed to other causes than hysteria.

These last examples bring us naturally to the forgetfulness that bears on movements. Movements, we know, are but the outward manifestation of certain images. These images, naturally variable according to individuals, are called motor-images, and their loss, which after all is but a real amnesia, is outwardly manifested by a kind of paralysis. Systematised paralyses, just like systematised anæsthesias, may be produced artificially by suggestion. We have already reported numerous examples of this.[1] N., for instance, is no longer able to fold his hands in prayer; is no longer able to make a knot in twine, etc. The same fact is produced naturally; such or such a patient knows no longer how to sew; another knows no longer how to make her bed. This motor-forgetfulness

[1] *Autom. psych.*, p. 357.

may bear on very special movements, as those of the eyes, and contribute much to what is called the external ophthalmoplegia of hystericals.[1] Celestine, for example, lost, after an attack, the power of looking voluntarily to the left. Her eyes stop at the median line as soon as you ask her to turn them to the left. The most important of these systematised paralyses is certainly the one that bears on walking. It forms a veritable syndrome, which has been very well described by M. Paul Blocq under the name of *astasia-abasia :* " It is a loss of the muscular synergies which insure the equilibrium in the vertical posture and in walking."[2]

In some of these cases the trouble is not simple; it is united with a fixed idea—that of walking on tiptoe, for example. The same as with Rem., who seems to be afraid, when she walks, of breaking eggs. But generally the patient presents no fixed idea, no clear paralysis; he has retained certain modes of moving—he can run, jump on one foot, walk on all fours, etc.; he has forgotten only " how one is to manage to walk." A very curious case reported by MM. Séglas and Sollier[3] shows us well the relation that exists between the disorders of motion and the so-called amnesias. The patient loses the power of walking, standing, sewing, and at the same time does not recognise her husband or her son, does not know the day of the week, does not remember anything of what is told her. There is with her " an analogy between the different phenomena of the intellectual domain and those

[1] Ballet, *Revue de médecine*, 1888, pp. 337, 513. F. Raymond et E. Koenig, "Sur la dissociation des mouvements oculaires chez les dégénérés hystériques," *Annales d'oculistique*, July, 1891.

[2] Paul Blocq, " Sur une affection caractérisée par de l'astasie et de l'abasie," *Archives de neurol.*, 1888, p. 43, "et les troubles de la marche dans les maladies nerveuses," 1892, p. 55. Paul Richer, *Paralysies et contractures hystériques*, 1892, p. 54.

[3] J. Sèglas et P. Sollier, " Folie puerpérale, amnésie, astasie, et abasie," *Archives de neurologie*, No. 60.

of the organic and secondary automatic domains."[1] All these facts, though apparently different, should be classed under the name of systematised amnesia.

Localised amnesias are still better known than the preceding. They strike the observer more. The events of which the remembrance is lost are gathered into a common characteristic. They all belong to the same epoch, the same period of the patient's life. Generally things take place as follows: After an accident or an emotion, the hysterical, who seems so far to be well, has a violent attack. When the crisis is over, the patient takes up again her usual mode of living; but the persons about her notice oddities in her conduct and words. In questioning her they discover that she does not remember certain periods of her life.

In the simplest case, but not the most frequent, the patient has forgotten only the principal events—her emotion and attack. It is what M. Sollier calls simple amnesia.[2] Often the subject has forgotten, besides the principal events, a certain period of her life preceding those events. Thus we have seen brought to the hospital of Havre a woman who had had an accident of this kind. In consequence of an attack in November, a few days before her coming to the hospital, she remained paraplegic and had forgotten all the facts that had occurred during the three preceding months; she would relate her life in detail at the beginning of August, but could say nothing of what had happened in September or October.[3] Sometimes the point at which this amnesia stops is perfectly clear. Mme. D. can relate in detail what happened on the 14th of July, and knows nothing of what happened on the 15th. In other cases, the last days of the amnesia

[1] Sollier, *Amnésies*, p. 205.

[2] *Ibid.*, *op. cit.*, p. 158.

[3] See, in *Autom. psych.*, p. 93, an observation of the patient described under the name of Rose.

are vague, and the subject remembers them but imperfectly. Finally, one should be cautioned against a very frequent difficulty in the examination of hystericals. Celestine, who likewise, in consequence of an attack, had a period of forgetfulness of this kind, would fill the void with imaginary events. These accidents are justly designated by the name of retrograde amnesia. We shall be satisfied at present to point it out; we may possibly return to it in looking for explanations that may be given for such or such particular form of amnesia. Again, amnesia may bear not only on the events that have preceded the emotion or the attack, but on the events which followed it. After a certain time, not very long, the subject, who seems to have recovered from his emotion and to be comparatively normal, awakens completely and reassumes entirely his ordinary psychological condition; we discover, then, that he has forgotten not only the event, not only what preceded, but also what followed it. We might call this forgetfulness "anterograde amnesia," for it bears on events that came after the principal emotion. M. Sollier calls it, with more precision, "anterograde amnesia of reproduction."[1] Let us not forget, however, that it is still a malady that affects only remembrances acquired before the moment of a complete awakening; it does not modify the acquisition of present remembrances; it is always a localised amnesia.

These localised amnesias are very often less important, especially much shorter, than the others. They bear, for instance, on certain actions which seem evidently to have been accomplished in an abnormal manner. Certain dreams at night, during which the patient is much agitated and speaks a great deal, certain deliriums which accompany the attack, certain abnormal states which sometimes follow the attack, seem to leave no trace in the memory. These facts being well known, we prefer

[1] Sollier, *op. cit.*, p. 79.

dwelling on other amnesias which bear on periods apparently normal. It will be quite to the purpose to quote on this point a few lines from a work of Dr. Despine (d'Aix), already old but very curious, which contains, to our mind, one of the first and most remarkable descriptions of the mental state of an hysterical:

Sometimes—he says, speaking of his patient—there was observable a very particular moral state, noted by Estelle's mother, for which she had not been able to account. They had been in the habit of reading together, a thing which greatly interested her daughter, but the child did not retain the least remembrance of it. They used to take her outdoors for an airing (Estelle was paraplegic) ; she saw all that passed around her, took an interest in it, talked about it, etc.; and, coming back, seemed to have forgotten all, or, if there remained any trace of it, the recollection was fugitive and like a vanishing dream.[1]

How many times have we not verified this observation of Despine; how many patients who appear attached to some reading or to a piece of work and who are not able, if you question them a few moments afterwards, to tell you what they have done! " These are attenuated second states," says M. Sollier, who has noted the same facts.[2] This characteristic seems to us very important; it shows that the hysterical is generally and naturally predisposed to localised amnesias. This explains, we think, many phenomena which are produced on them artificially, and which are but a special application of this constant predisposition.

In cases infinitely more rare, *amnesia* may be *general;* the patient, after a series of attacks or sleeps, may have apparently lost entirely all the remembrances acquired in

[1] Despine (d'Aix), *De l'emploi du magnétisme animal dans le traitement des maladies nerveuses*, 1840, p. 12.

[2] Sollier, *op. cit.*, p. 199.

her life. It would seem that she is born a second time, and that she has to learn over again all she has learned in her childhood. We shall not dwell on this strange form of hysterical amnesia, because the rare cases of this kind which have been observed are well described by several authors,[1] and because we have not had an opportunity to observe any ourselves. Certain patients have been obliged to learn again how to read, write, to pronounce even the simplest words. As M. Ribot says, they have to be re-educated. The celebrated observations of Mortimer Granville, Sharpey, Macnish, etc., are reproduced everywhere. Mary Reynolds's case is less known, and it is a pity, for it is a most curious one; it was published by M. Weir Mitchell.[2]

Mary Reynolds in her childhood seemed to enjoy good physical and moral health; she was intelligent, calm, somewhat reserved, and sad. At eighteen she had a few syncopes and hysterical attacks. After one of these attacks, exceptionally violent, she remained insensible, blind, and deaf. Five or six weeks later her senses returned gradually, but then she sank into a profound sleep which lasted twenty hours. When she awoke, she had lost absolutely all remembrance; "she was like a creature coming into this world for the first time."[3] All that she had retained of the past was the faculty of pronouncing a few words instinctively and without attaching any sense to them. "Her eyes seemed to open upon the world for the first time." Persons, houses, fields, trees, all seemed unknown things; she had to learn everything anew; "in a word, she was a child just born, with the faculties of the adult." We do not intend now to investi-

[1] Ribot, *Les maladies de la mêmoire*, 1883, p. 63.

[2] Weir Mitchell, *Mary Reynolds*, a case of double consciousness, Philadelphia, 1889.

[3] *Ibid.*, *op. cit.*, "To all intents and purposes she was as a being for the first time ushered into the world."

gate this case of second existence; we only point out this extraordinary example of general amnesia.

Continuous amnesias.—All the preceding amnesias were, as we said, the loss of real remembrances which had formerly been acquired and which had several times been manifested as remembrances. Hystericals can present a quite different modification of memory, more serious perhaps than the preceding. Remembrances may suffer alteration in their very formation. The patient may continuously lose the faculty of acquiring remembrances; amnesia goes ahead, it is *anterograde*, as Professor Charcot said;[1] *anterograde of conservation*, as M. Sollier also says.[2] If we dared to modify the established usage, we should say that it is not, properly speaking, an amnesia—namely, a loss of remembrances, since there are no remembrances at all; it is rather a trouble in the way of perceiving things, a fault of attention; but since the principal manifestation of this alteration is in reality an absence of the remembrances which a normal man would have had, we shall describe the symptom as an amnesia, and study its mechanism, treating the troubles of attention, of aprosexia.

Almost all hystericals present this amnesia to a certain degree; it enters largely into what is commonly called their absent-mindedness, their heedlessness. A. cannot remember the road she was made to take and gets lost in the streets coming home; she loses her place as servant because, notwithstanding her good will, she forgets all the orders that are given her. C., a man, began with localised amnesias, then his forgetfulness increased; now he forgets almost everything. "I talk with someone and as soon as his back is turned I know no longer who he is or of what I have spoken." Another can never find her

[1] Charcot, "Sur un cas d'amnésie rétro-antérograde, probablement d'origine hystérique," *Revue de médecine*, February 10, 1892, p. 81.

[2] Sollier, *op. cit.*, p. 159.

things, for she always forgets where she put them. Many authors have pointed out facts of this kind.[1]

But, in order to study this symptom, we must choose cases where it shows itself much clearer and altogether predominant. It struck us particularly in a patient in M. Falret's service, Marcelle, upon whom we studied an essential characteristic of hysteria, viz., the absence of will, abulia. The remarks we made touching her intelligence and memory were as follows: "At first you think you are talking to an intelligent person; she generally talks fluently when she is not intimidated; she shows some education, and on certain subjects, in particular when talking about her father, she gives evidence of a nicety of judgment; but if we try to estimate her intelligence by the criterion in general use, if we endeavour to find out what she has learned, how she understands the things that pass around her, if we question her concerning her stay at the hospital, then, indeed, we shall wonder at her ignorance. She has now been a year in the service, and she has seen nothing, understands nothing about it; she scarcely knows the infirmary nurses who take care of her and of whose administration she has no idea; she has not taken notice of the patients, and, indeed, knows no more of the general service than would an idiot. In a word, she seems to present the results of a past not a present intelligence. This queer form of intelligence will be explained by the following analysis:

Marcelle's memory, in fact, presents the same kind of character. When she relates the incidents of her past life, we observe that her story is clear, exact, rich in details, but only so long as it runs over her childhood, before she was fifteen, the beginning of her malady. From that moment the remembrances decrease and become vague; at nineteen they fail

[1] Raymond, "Anesthésie cutanée," *Revue de médecine*, 1891, p. 396.

almost entirely and are limited to some few salient events. Finally, if you question her touching the last months or weeks just elapsed, you will discover to your surprise an absolute forgetfulness. Her old remembrances are preserved, but she herself has become more and more incapable of acquiring anything new, any new remembrances. This forgetfulness regarding recent events is very curious for its rapid occurrence and completeness. Marcelle cannot tell us what happened the day before; often at noon the whole morning has slipped from her mind. A word from her tells the situation: "Is it possible that I have been here a whole year? What a strange year in which nothing has happened!" In a young girl of twenty-two, such a memory is an old man's who can recite the *Æneid* and cannot remember what he has done in the morning. . . .[1]

We have since met with similar facts among various patients. Maria, for example, undertakes to read a novel, but her neighbours call our attention to the fact that she spends the whole day reading the same page; when she comes to the bottom she stops a moment and regularly begins again at the top. Besides, when we asked her what she had read, she was not even able to tell the title of the novel. She could never, though we insisted, and she did not mind the work, learn by heart a few lines. Sometimes the forgetfulness was immediate. She could answer only questions rapidly put to her; otherwise she remained amazed and said: "What is it you asked?" She would forget her own questions and say: "What is it I was talking about?"

MM. Séglas and Sollier published an observation, already alluded to, in which they describe a patient who, with many other troubles of memory, presents the following high degree of forgetfulness: "How queer; two nights in succession! We have just had one night, and

[1] "Étude sur un cas d'aboulie et d'idées fixes," *Revue philosophique*, 1891, i., p. 383.

here is another night that begins."[1] It is as bad as Marcelle's.

These different examples, already quite striking, do not yet show us continued amnesia absolutely complete and always the same. It is on a very curious patient of the Salpêtrière, already studied by Professor Charcot,[2] and by M. Souques,[3] that we have been able to see continuous amnesia in all its clearness.[4] Mme. D., in consequence of a violent emotion on August 28, 1891, had a serious attack of hysteria. She awoke from the attack in a peculiar mental state: (1) she had forgotten all that had happened during the two preceding months, and (2) she found herself incapable of acquiring any new remembrance; the most striking events,—the bite of a mad dog, the journey from C. to Paris, the vaccinations at the Pasteur Institute,—nothing of all this took a sufficient hold of her mind to leave a remembrance in it. Amnesia retrograde and anterograde, Professor Charcot correctly called it.

Persons who have little memory retain exact recollections for only a short time,—a few days, for instance,—or they keep in mind but the most interesting events. Mme. D. has not a feeble memory: she has none at all. In the spring of 1892,—that is, eight months after the initial emotion,—she forgets entirely and in less than a minute a name, a fact; and indeed what lasts longer, is the perception of objects, the effort she seems to make to

[1] Séglas et Sollier, "Folie puerpérale, amnésie," etc., *Archives de neurol.*, 1890, No. 60.

[2] Charcot, "Sur un cas d'amnésie rétro-antérograde," *Revue de médecine*, February, 1892, p. 81.

[3] Souques, "Essai sur l'amnésie rétro-antèrograde dans l'hystérie, les traumatismes cérébraux et l'alcoolisme chronique," *Revue de médecine*, May, 1892, p. 367.

[4] We have ourselves presented a study on this case and on the preceding ones at the Congress of psychology held in London, August, 1892. This work will be published in the *Revue générale des sciences*.

retain the initial impression; but she has no recollection, properly so called, for she is incapable of reproducing an image of the sensations she has allowed to become extinct. Let us add that this profound and fast-travelling amnesia was continuous and invariable, a thing we had not seen in the previous observations. We never saw Mme. D. show more memory at any time. Let us say, moreover, that this strange psychological perturbation was prolonged into the month of May, 1892—that it lasted, consequently, nine complete months without modification—and we shall have shown that it is the most curious case of continuous amnesia that has ever, to our knowledge, been pointed out. It is certainly an unique case and somewhat complex; so complete an amnesia was not, we think, a primitive stigma produced solely by a natural development of hysteria; it was an accident rather than a stigma. It comes close, however, to the other phenomena of amnesia; it completes them and helps us to understand them.

All hystericals are not so amnesic as Mme. D., but they seem to come close to this model, for, as we have seen, they all present, more or less, the one or the other—diverse systematised, localised, general, or continuous amnesias.

§ 2—ANALYSIS OF THE PSYCHOLOGICAL CHARACTERISTICS

The psychological characteristics of the hystericals' amnesia are so like those of their anæsthesia, that in their description we can follow the same order and present the same remarks in an abridged form.

1. In the systematised amnesias we see exactly, as in the anæsthesias of the same kind, the *influence of the subject's thought*. We see the remembrance which the subject pretends to have forgotten play its part and determine his choice of things forgotten, like the sensation

apparently not felt of the *marked points* (points de repère), which helps the subject in recognising the bit of paper he must not see. In the experiments of suggested systematised amnesia this is evident; but let us consider one that is natural. Celestine pretends having completely forgotten us, having absolutely no recollection of us. Be it so; we question her about what she did this week, and she recovers about all except one incident. She does not remember at all having been examined in the parlour by Professor Charcot. Now, it was we who introduced her to Professor Charcot. How, if she has no remembrance of us, does she so cleverly choose to forget the incident wherein we were concerned ? The thought of the subject intervenes in the same way to fix the limits of the localised amnesias. A young woman, married a year ago, has nervous attacks during her confinement. She becomes amnesic and forgets both her confinement and the previous period. Where does this retrograde amnesia stop ? At the marriage. The young woman forgets the period that comprises her delivery, her pregnancy, her husband, her marriage. By this delicate association of ideas we recognise an hysterical.[1]

2. In the same way as anæsthesia does not suppress reflexes which depend, however, on sensation, so does amnesia not *interfere with the intellectual function*, which is, nevertheless, the immediate consequence of memory. This is all the more clear when we consider a serious amnesia,—a general amnesia, for instance. Authors, like Dr. Weir Mitchell, always say[2]: " Despite the loss of memory, the intelligence remained intact; as soon as she again learned to speak she expressed herself both sensibly and reasonably." Let us suppose such an amnesia, brought about by the progress of dementia, such forget-

[1] Lettre de Ch. Villiers à G. Cuvier, d'après Ribot, *Mal. de la mémoire*, 1883, p. 62.

[2] Weir Mitchell, *Mary Reynolds*, 1889.

fulness of all notions, even of writing and speaking, and we have before us a completely stupid individual. Is it not surprising that an hysterical with so formidable an amnesia should remain intelligent ?

3. If we omit quite particular cases, such as continuous amnesia, we can say that the hysterical is as *indifferent* to her amnesia as to her anæsthesia. That the hysterical should have forgotten two or three months of her life does not seem to disturb her much, unless there be very special circumstances that cause her to notice her forgetfulness and induce voluntary questionings. This is so true that hystericals do not complain of it, and that generally they even ignore it, we think. Rose, when brought to the hospital, complained only of her paraplegia, and never said a word of that great localised amnesia which she had had for three months and which we were so surprised to discover. As Professor Charcot said of anæsthesia, amnesia was also a characteristic that had to be searched for.

4. Lastly, we shall find again in amnesia the two primary characteristics of hysterical anæsthesia — namely, mobility and contradiction. Let us first look into *mobility*. Usually a serious amnesia is due to the destruction of traces, of unknown modifications which the sensations leave in the brain, and which allow them to reproduce themselves under the form of images. Let us suppose a definitive and material destruction of the cerebral cells which have stored up these modifications, and the remembrances of these sensations will be materially destroyed in an irreparable way. Is it so with hysterical amnesias ? Certainly not; we may be sure that in every hysterical amnesia the preservation of remembrances is still maintained. This is proved by the mobility of these anæsthesias, which acquire thus a considerable psychological importance.

It was long since remarked that this deep-seated

forgetfulness is not perpetual, and that, from time to time, under various influences, it momentarily disappears. The subject recovers all the remembrances he seemed to have forgotten. He knows them in all their details, he resumes the life he seemed to have definitively abandoned right at the point where he had left it off. Perhaps, after a time, he will lose those remembrances again, but their momentary resurrection is enough to prove that the images had been preserved. This is what is designated by *periodic amnesia*. It is known that some of these patients who, at a given moment, have presented general amnesia, and who have begun their life over again from their first childhood, do not definitively preserve this new infantile existence. After some time, at the end of some ten weeks, according to Dr. Weir Mitchell's observation, Mary Reynolds had a second period of sleep and awoke such as she was before her accidents, with the complete memory of her whole life. It is true that she had no longer now the remembrance of her second state; but we need not be uneasy about these remembrances of state number two; they reappeared in consequence of a new attack which was not slow in supervening. Thanks to these alternations of the two states, we see that in reality no remembrance has been lost.

We did not think it necessary, and for an excellent reason, to establish a class for periodical amnesias. We have treated only of hysterical amnesias, and think that all hysterical amnesia is periodic. Very often this periodicity establishes itself, and attacks or sleeps, or such varied accidents as change the mental equilibrium, bring regularly to light now one remembrance, now another.[1] Marguerite has had violent attacks these two years, and in consequence of these attacks she enters into a rather complicated somnambulic state. It is sufficient now to know that it is a spontaneous state, which is part of the

[1] *Autom. psych.*, p. 77.

hysterical crisis from which she issues with convulsions. She never knew, on awakening, what happened during this period. A very clear localised forgetfulness seems to be here. At the next attack, which will take place in a fortnight, she will re-enter the same state of somnambulism and will recover all the remembrances seemingly lost.

Natural sleep, as we have already seen while studying sensations, may also show us mobility, the periodical character of these amnesias, and the real conservation of the remembrances. We know how Professor Charcot noticed for the first time this preservation of remembrances in Mme. D., this patient who did not seem to retain any image of any kind in the mind. She spoke aloud at night, murmured words her neighbours could hear. When she dreamed she spoke of the mad dog, of the Salpêtrière, of the physicians in their white aprons—in short, of all she appeared to have forgotten. We have very often seen a person, hypnotised during the day, forget everything when awake, and relate aloud in the night, as Lucy did, all that was done with her during her somnambulic state. Sometimes these recollections of somnambulism reappear in a more curious way; they are not expressed aloud by the subject, but they present themselves to him during the sleep as an ordinary dream. Now, as we can generally remember such dreams, the subject, by means of this intermediary, recovered the memory of his somnambulism. It is thus that B. and Justine forget their somnambulic state at the moment of waking, and yet know of it sometimes the next morning. The attack and the natural sleep are not altogether at our disposal; we can, in certain cases, use a still more practical process. We can artificially, through induced somnambulism, reproduce those states in which the remembrances that have disappeared are manifest anew. Bertha, for instance, is very easily hypnotised. Let us not now investigate hypnotism, which, perhaps, as in

other cases, may be a name confusedly applied to various things very different from each other. We recall here only an already established fact: hypnotism is just a state that leaves no remembrances with the patient when he awakes. This forgetfulness is more or less clear, more or less rapidly obtained after the first hypnotisations; but it is in our eyes a characteristic of the more or less serious state of somnambulism. With Bertha it existed when we first put her to sleep. This fact is not surprising. She is a young girl predisposed to the phenomenon, having naturally and at every instant localised amnesias analogous to those which have been described by M. Despine. She had for many years, and before she came to the hospital, natural somnambulic sleeps, first at night, and next, which is not surprising, also in the day time. Hypnotism, with her, consists simply in reproducing artificially one of those numerous conditions, followed by amnesia, into which she entered of herself every instant. She appears, when you wake her, to have entirely forgotten what occurred while she was sleeping. Formerly, when, after her spontaneous hypnotisms, she was shaken in order to awaken her, she looked all amazed, having wholly forgotten the message she had been intrusted with a moment before. Well, this forgetfulness is but an appearance, an illusion; it is enough to put her asleep again, to put her back again, by means of suggestion, if you like, or better, through automatic habit, into a moral state analogous to the one she has just issued from, so that she may recover all her remembrances. With her this operation is very simple; for, from the beginning of the hypnotic state, all amnesia, like all anæsthesia, completely disappears. Not only does she recover the remembrances of the induced, but also those of the natural, somnambulisms, of the crises—even those of the strange periods of waking hours which are instantaneously forgotten.

This search after remembrances that have disappeared is not always so easy. Margaret, once hypnotised, has not the complete remembrance of all the natural somnambulism which follows the attack; she can remember only the first part of the crisis, that, namely, during which she keeps her eyes shut. But if, during her hypnotic state, you open her eyes, she experiences what is far from being general, namely, a modification of her mental state, and she takes up the remembrances of the second period of the crisis, namely, that during which she had also her eyes open. We have already spoken of varied somnambulisms in which the state of sensibility becomes modified. Now, in these states, memory becomes equally modified, and, by a sort of feeling about, one can almost always succeed in restoring the particular remembrance that is desired.

Sometimes even we can dispense with somnambulism. By means of suggestion, or, thanks to the association of ideas, or still better, by directing well and sustaining the attention of the subject, we can make him recover lost remembrances. Of course, we speak here only of the minor hysterical cases of forgetfulness. Where there is a very clear amnesia of the pronounced type, we must nearly always have recourse to an attack or to the somnambulic sleep. With Mme. D., for example, you obtain nothing by trying to direct conscious attention during waking hours; you make her, on the contrary, recover all her remembrances by putting her to sleep. In a word, it is the mobility of these amnesias that is the cause of their periodic character and that proves that the preservation of the remembrances is retained.

5. Anæsthesias have presented themselves with a *contradictory character;* we think it is the same with amnesias. We have already noticed how peculiar general amnesias are. M. Weir Mitchell tells us that Mary Reynolds is like a new-born child, but a child enjoying the

intellectual capacities of the adult: "Reason, with her," he says, "is being exercised without any data." Now, we confess that we do not understand what that means. What is this abstract intelligence, this occult power, which exists all by itself? The intelligence of the adult is simply the sum of remembrances, of associations of ideas, of preorganised tendencies to pass from one image to another. The lack of intelligence in the child is precisely the absence of this organisation. Psychologically as well as physically, one cannot be both a child and an adult. Either Mary has indeed lost all her remembrances and has the mind of a child newly born, and then she is unintelligent, stupid, like a child new-born, or she is intelligent, and then she has not lost her remembrances. Besides, we see every moment these remembrances manifesting themselves. The patient relearns extremely fast; she knows an old song better than a new one. "When she sings she generally needs to be assisted for the first two or three words of a line; she finishes the rest *from memory, it seems*. . . . When she was asked where she had learned the air she was playing, looking at the music-book, she replied that she could not tell and wondered that her interlocutor could not do as much."[1]

These facts are extremely important, inasmuch as they show us not only the preservation but even the reproduction of images, despite amnesia. We know that the reappearance of images at the opportune moment is an essential condition of complete remembrance, and it is naturally thought that this phenomenon is changed in hysterical amnesia. Mme. D., for instance, seems to be unable to reproduce images except in dreaming, during her sleep, and not to be able to reproduce them when necessary, according to the necessities of the waking hours. The contradictory character of these phenomena is such that,

[1] Observ. de Sharpey, d'après Ribot, *Mal. de la mémoire*, p. 67.

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despite apparent amnesia, the remembrances can be reproduced, if necessary, even during waking hours. Mme. D., if we are not mistaken, has all this while in her mind and on her lips the reply to the question which is put to her or which she puts to herself. Why do we imagine such a thing when the poor woman declares herself so unhappy, and pretends that it is absolutely impossible for her to recover the least remembrance? It is because we have already seen similar things among hystericals. We have seen that they do not appear to see, to feel, and that, at that very moment, they have tactile and visual sensations in their mind. We might ask ourselves if it could not be the same for images so little different from sensations. Certain acts of the patient had started this supposition long before we had been able to verify it by experiments. Mme. D. forgets everything in a minute and cannot succeed in knowing any of the people in the hospital; however, when she goes into the yard, she always spontaneously turns to sit down by the people who take care of her. Every time she meets a dog, even the gentlest, she runs, hiding her face and uttering cries of terror. It is not enough to say that she is afraid of dogs, for, if you question her about her past, she will tell you that formerly, even in July, dog-days' month, she was not afraid of these animals. Whence this change? Evidently the bite of the mad dog which happened in September and the cauterisations which followed started it. But now, she does not remember the accident and does not know why she is afraid; this remembrance, then, is reproduced without her knowing it.

We have verified this subconscious reproduction of remembrances by many experiments, especially by suggestions which were executed at the given hour, despite amnesia. But here is the process which, it seems to us, manifests the fact most clearly:

If we question the patient in a direct manner, if we ask

her to pronounce or even to write voluntarily the name of the house physician who takes care of her, we discover that she appears to make an effort, but declares herself incapable of writing the name. We have to proceed in another way. We step away from her and ask someone else to talk to her; she replies to this person's questions, seems to pay attention to what is said to her, and does not mind us any longer. We slip a pencil into her right hand and she takes it without turning round; quite odd, but this is the case with most hystericals, whose mind, as we have seen, is easy to divert. Let us take advantage of this inclination, and, while Mme. D. continues talking with someone else, let us make her a suggestion as if she were able to understand us: " Write down," we say to her, " the name of the doctor of your ward." We see the hand that holds the pencil begin to move and write, " M. Lamy." In the same way we ask her what is the matter with her left hand, and she writes without hesitation, " I cut myself with some glass." In a word, she will answer in this way all possible questions, and, in her writing thus obtained, will show us the recovery of all the remembrances which she seemed to have completely lost. We do not mean to study here this writing, which, besides, is not particularly remarkable. We do not care to show that in reality Mme. D. insists that she had not heard our questions, had written nothing, and wonders at this writing when shown to her, declaring that it is not hers. These are details we can for the present dispense with. What we wish to establish is, that this involuntary writing, at least in appearance unconscious, proves remembrances which Mme. D. is incapable of possessing otherwise when awake. You must not think that we attribute here to the writing a wonderful power in bringing to light Mme. D.'s remembrances; no, for we have succeeded in manifesting these remembrances in another way, namely, by word of

mouth. But this patient, it will be said, never succeeds in telling them. No suggestion has as yet been able to cause her to express them. No doubt. We shall therefore have recourse to a process which sometimes succeeds. We are going to divert her mind once more, avoiding this time drawing her attention to speech. We give her a book to read, or rather a multiplication to make. While she is well absorbed in her work, we notice the same phenomena of mental diversion; we can touch her, whisper to her, without her turning round. We speak to her thus: "What are the names of the two patients, your neighbours in the ward?" Her lips move, and she replies in a low voice: "Mme. C. and Mme. P." We might even command her to speak louder. If she is well absorbed by her reading or multiplication, she will repeat it quite loud and correctly. A new fact again, from which we draw but one conclusion still: the recovery of remembrances exists with her; it seems to take place normally according to necessity.

It is about thus with all subjects and all forms of hysterical amnesia when we succeed in inducing automatic writing or at least make manifest by any kind of process subconscious phenomena. Maria wrote thus, without knowing it, the subject of the novel which she had been reading indefinitely without being able to recall a single line. Bertha and Georges have thus rewritten a letter which they had written while in a state of natural somnambulism, and of which they could not consciously recall the remembrance. True, sometimes it is necessary to vary the process very much, to vary it according to the subjects. This writing at times does not recover the remembrances except during special states. There are even very notable exceptions which depend, no doubt, on the complicated play of certain associations of ideas. But the positive facts are sufficiently numerous to enable us to compare, on this point, amnesia with anæsthesia.

Here, again, there is a contradictory characteristic in the way in which remembrances are reproduced. On the one hand, they are present; on the other, they seem to be absent. This problem of the same kind can, we think, receive an analogous solution.

§ 3—Attempt at interpretation

Now, where shall we look for this alteration of the memory which must exist somewhere to produce such manifest results ? The psychologists in their descriptions admit of no other elementary phenomena of memory than conservation and reproduction. We think that they are wrong, and that disease decomposes and analyses memory better than psychology.

We shall have made a first step if we observe that the question here is of a fact analogous to absence of mind. There are absences of memory as of sensations, and they bring with them forgetfulness as these produced anæsthesias. Lucy refuses energetically to relate something in our presence. We have but to step aside and, while remaining close by, letting her prattle with someone else, she forgets our presence so entirely that she relates to that person all she would not tell before us. Bertha is very angry with us. If we try to discuss the motive of her spite, she becomes more and more so. We change the subject, and the next instant she follows the new subject and forgets the first completely. Inversely, we can see the part absence of mind plays by trying to suppress it by attention. With some subjects, as we have seen, we can, by encouraging them, by directing their attention, cause momentarily their amnesias as well as their anæsthesias to disappear. But they require for this a very great effort of attention, a thing of which they are rarely capable. Generally, they have a weak attention,

which serves only to convince them of their forgetfulness. Let us then admit that hysterical amnesia is also a form of absent-mindedness.

But we cannot stop here, for this amnesia presents itself in the light of a very strange absent-mindedness, whose cause and nature we must investigate. As has been demonstrated in the preceding chapter, it is not enough for a simple, isolated sensation to be produced in the mind, to be for this reason appreciated by the subject. It is necessary, for the complete consciousness of a sensation, a sensation that can express itself by "I feel," that a new operation should be added to the first. It is necessary that a sort of synthesis should gather together the sensations produced and connect them with the mass of anterior ideas which constitutes the personality. This should be the same for the images. It is not sufficient, in order to have the consciousness of a remembrance, that such or such image be reproduced by the automatic play of he association of ideas; the *personal perception* must also seize upon the image and connect it with the other remembrances, with the sensations clear or confused, exterior or interior, the ensemble of which constitutes personality. Call this operation what you will,—give it the name *personification*, or be satisfied with the common terms we have always employed, *personal perception of the remembrances* or *psychological assimilation of images*, we must still establish its existence and make a place for it in the psychology of memory, as well as in that of the sensations.

This operation is with us so simple and easy that we do not even suspect its rôle. But it may be altered and suppressed, while the other phenomena of remembrance, conservation and reproduction of the images persist in their integrity. Its absence will be enough to produce in the patients a disturbance of memory which will be, *for them*, a real amnesia; and we think that, in most cases,

hysterical amnesia is nothing else than an amnesia of this kind, a simple *amnesia of assimilation.*

Let us examine now, as we can do so, the conditions under which this mobile and contradictory amnesia manifests itself or seems to disappear. Let us take as example especially Mme. D.'s case, because it is one of the clearest. Under what circumstances is remembrance absent with her ? When you question her directly, calling her by her name, or when she questions herself. In a word, remembrance seems to disappear every time her personality is concerned, every time she is compelled to say, " I remember." The remembrance, on the contrary, seems present in various other circumstances—in dreams, hypnotic sleep, thoughtless acts, writing, and speech obtained while the patient's mind is diverted by another conscious operation. Here, again, there is a common character: remembrance presents itself when the clear and personal consciousness is absent, when the remembrance is isolated, and without relation to the complete life of the patient.

This characteristic is very visible in her somnambulic state. This state, in fact, is essentially Mme. D.'s. It is not, as with other patients, a second form of psychological existence, with remembrances of its own and the formation of a second personality. No, it is with her a wholly inferior form of the somnambulic state; a form which seems indistinguishable from a deep sleep in which she has no thought, no spontaneity; we might almost say, no personality. When we try, even during the somnambulic sleep, to realise a personality, to connect through remembrance her various induced somnambulic states, it is seen that the memory disappears anew. Remembrance, even during the somnambulic state, exists only on one condition: The patient must not be conscious of anything, must reply to questions automatically, through the mechanical association of ideas, without reflecting, with-

out a personal perception of what she is doing. Of course, the mechanism of the return of the remembrances during the somnambulic state is not always this particular one; but we cite this example to show that the remembrances persist and manifest themselves in an automatic manner without personal perception.

The same characteristic is still clearer, we think, if we examine the remembrances manifested by automatic writing or speech. These two interesting experiments are very difficult and often fail. Why? Because, as soon as the subject pays attention to his writing, all stops, and he is no longer able to obtain the manifestation of the remembrance. Conscious attention, far from facilitating automatic writing, as would happen to a simulator, absolutely suppresses it. Remembrance, in a word, manifests itself only unconsciously to the person; it disappears when he tries to speak or write in his own name.

We fear, by expressing the conception of hysterical amnesia in this way, we may appear to run into a dangerous excess. How, it will be asked, can the forgetfulness of hystericals—that, namely, which follows upon somnambulic states, upon crises, which is continuous with Professor Charcot's patient—be nothing more than that,—an absent-mindedness of the personality? Why, then, it does not amount to anything, and you may as well say that this forgetfulness does not exist—that it is just a piece of good-naturedness on the part of the subject. By no means; this forgetfulness is very real, very painful to the patient; it is a slight psychological lesion, and it is none the less an infirmity. The forgetfulness of Bertha, which happened at any moment of the day, and which we can reproduce at will and apparently with such ease, was the cause of her being dismissed from the store where she made her living, reducing her to misery. Mme. D.'s forgetfulness has obliged her to come to Paris, to enter the Salpêtrière and remain many months,

separating her from her husband, her children, who yearn for her and need her. A lesion, to be a moral lesion, is not the less real and often very serious. You may be shut up all your life in an asylum for a simple disturbance of the idea of personality.

Hysterical amnesias, like anæsthesias, may be represented as troubles of this kind. The elements of remembrance, the conservation and the reproduction of the images are intact; but there is a lack of the real synthesis of the psychological elements which suppresses, more or less completely, the assimilation of the remembrances to the personality.

§ 4—SOME PARTICULAR FORMS OF AMNESIA

The attempts at interpretation which we have just made have borne only on the phenomenon of amnesia in general—on its nature and the conditions of its production. But amnesia does not in reality present itself in this vague way; it bears on such or such a fact, very precise and distinct from the others. Why does amnesia take these particular aspects; why is it at one time, at such or such a period of life, now systematised, now localised, now general? We do not hesitate to confess that we do not know, and that we have not found any explanation that applies to all cases. It will require many more studies before we can interpret the details of these phenomena. Yet we have observed a certain number of particular facts which are not connected with each other and do not exhibit any general law, but which may be pointed out as preliminary observations—building-stones awaiting future constructions. Amnesias and their localisations seem to us to depend, sometimes, (1) on the state of the subject at the moment when he acquires the remembrance; (2) on the state of the subject at the moment when he tries to reproduce the remembrance; (3)

on the nature and development of the forgotten phenomena; (4) on the modifications of sensibility.

1. A remembrance may be insufficient because it has been incorrectly acquired, badly organised, from the beginning of its formation. When a patient passes through a period during which he is particularly feeble and synthetises very badly not only his images, but even his actual sensations, he is incapable at that moment of laying a foundation for future remembrances. Later on, even if he is better, he will not recall the remembrances of this unfortunate period, while he will recover remembrances of a neighbouring period when the syntheses have been more fully effected. A patient, Marcelle, had usually very little psychological strength, either to accomplish voluntary acts or to perceive consciously outward phenomena; but, from time to time, in consequence of a prolonged sleep, for example, she had "clear moments," during which the exterior perception of objects and even the interior perception of her own personality appeared transformed and much stronger. These two states leave very different remembrances. While she completely forgot the remembrances of the "dark periods," she remembered indefinitely the events of the "clear moments." An example will make the remark clearer:

During one of those clear moments, awakening from a somnambulic sleep, Marcelle saw on the table some pieces of metal, fragments of a dismounted electrical apparatus. Oddly curious at that moment, and curious only at such moments, she wanted to know about these pieces of copper, and was satisfied only when we had explained their use to her. A short time after, she fell back into the gloomy state which was her usual condition. A week and even two weeks later, we had but to touch upon this incident and ask her what she had seen with us in the cabinet, and she described exactly the meaning of those fragments of the electrical apparatus. On the contrary, all the events that occurred in the interval, which might have

been as striking, as a visit from her parents or the quite recent facts that had happened during the morning, were entirely forgotten. It is, then, indeed, the alteration of the perception which causes the alteration of the ulterior memory. Besides, we were determined to verify the fact by observation, although it might have been foreseen by reasoning. Memory is only the preservation of a synthesis previously made; it is plain that memory will not exist when the synthesis has not yet been effected or when it is but half effected and remains unstable and fragile. It is said that memory is a corporeal function, that remembrances have in some sort got into the organism: no doubt, yet they must have become organised. To establish remembrances, to create habits, is one of the prerogatives of mental activity.[1]

It is in this case that remembrances are most completely absent; that they are vague and difficult to recover even in subconscious states. The forgetfulness and localisation of amnesia depend here on the state of mind at the moment when remembrances are acquired.

2. Forgetfulness may depend, not on the past state, but on the actual state of the subject at the moment when he tries to call up the remembrances and connect them with his present personality. Margaret has usually but a slight amnesia. She is capable, by an effort of attention, of recovering well-nigh all her remembrances, except those that occurred during crises and somnambulic states. But it will happen that at certain moments her memory appears to be utterly destroyed; she remembers nothing; she forgets even the facts of current life which she usually retains. By this diminution of memory, as by the greater retraction of the visual field, we can prognosticate a near attack with her. Later, she herself will describe this state quite well. "I know now why I could not remember anything; it is because I could not look back to find it; I could not follow an idea, nor hold it

[1] "Aboulie et idées fixes," *Revue philosophique*, 1891, i., p. 393.

fast; my head was empty." Amnesias of this kind are ordinarily general, and bear on nearly all kinds of remembrances; but yet, like all others, they suppress only the personal perception of the remembrances which are easily manifested in a subconscious state. It is in this case the present state of the mind which determines the amnesia of the past.

3. There is a very strange form of amnesia which for a long time yet will trouble psychologists; it is a form of localised, retrograde amnesia. M. Ribot began the study of this phenomenon when he spoke of the law of regression touching remembrances.[1] He showed that the recent remembrances were less stable than the old; but without being able to give the reason of the fact. M. Sollier understands the interest of this curious problem, and has added a few interesting and ingenious remarks to his interpretation.[2] For example, he has taken up again the examination of the laws indicated by M. Ribot; he thought he could find in the more frequent repetition of the old remembrances the reason of their greater stability. As he supposed,—with a little too much subtlety, we think,—the patient's amnesia extends over a period corresponding to the presumed duration of the accident that befell him, and, by an illusion, he represents to himself this duration as much longer than it was in reality. He has also made a remark which must sometimes prove true, namely, that the accident which caused the amnesia must be associated with the facts that preceded and prepared it, and it carries them with it into the same forgetfulness. M. Sollier must think as we do ourselves that these are not definitive explanations, and that they apply from time to time only to very particular cases. Nor have we any explanation for retrograde amnesia. We wish only to call attention to a detail of the phenomenon. This kind of

[1] Ribot, *Les maladies de la mémoire*, 1883, p. 88.

[2] Sollier, *op. cit.*, pp. 48, 69.

amnesia is much more frequent than is thought; it accompanies nearly all the other localised amnesias. The old magnetisers often noticed it, and M. Bernheim but recently insisted on this point.[1] Nearly all induced somnambulic states, even the shortest, are accompanied with retrograde amnesia. Here is an example of the fact: We take Bertha along with us while she is well awake; we make her talk about various things; we send her on errands, particularly to get matches; she is next bid to make a fire; the whole lasts about twenty minutes, when we put her asleep. When, an hour later, she is awake, she asks, wonderingly, who lit the fire. Yet it was herself who lit it, she being entirely awake a quarter of an hour before we put her asleep. We establish that she has forgotten not only the period of the somnambulic state, properly so called, but also the twenty minutes which preceded it. It is the same with Fernande, Margaret—in a word, with nearly all somnambulists. But the fact is still more general. We know that some suggestions are forgotten after being acted upon. This forgetfulness bears not only on the performance of the suggestion, but on the acts immediately preceding it, which, however, were not suggested acts. It is exactly the same as to certain impulsive acts. In short, the subconscious phenomena of automatic writing carry off with them not only the forgetfulness of writing itself, but also the forgetfulness of the surrounding acts effected before, during, or even immediately after, the automatic writing.

If, now, we consider things from another standpoint, if we try to find the remembrance of those acts which seem forgotten, we shall see that, in a new somnambulic state, Bertha will find again not only the remembrance of the first somnambulic state, but also of the preceding acts, and, in particular, of the fire she lighted. In somnam-

[1] Bernheim, "De l'amnésie rétroactive dans le sommeil provoqué," *Revue de l'hypnotisme*, 1889, p. 12.

bulism, equally so, the remembrance of the performance of the suggestion comes back, and is accompanied with the remembrance of the surrounding acts. Not only will a new automatic writing be remembered of itself, but also the neighbouring acts. In a word, everything goes on as if these anterior or even posterior periods were henceforth a part of the abnormal state. We can express this by saying that the abnormal state is *invading*, that it absorbs all neighbouring events and carries them off with it into subconsciousness. This invading character of certain moral phenomena is very remarkable; it plays a great part in the pathology of fixed ideas. This is by no means an explanation of the retrograde amnesia, which remains, for us at least, a very mysterious thing; it *is* a small additional detail of which we should take note in our study of it. It shows us that sometimes the extent of amnesias depends on the phenomena themselves, which are forgotten. These phenomena are not entirely destroyed; they are not inactive; they continue to act either to increase the amnesia or to diminish it.

4. Finally, we believe it necessary to insist in certain cases on the modifications of sensibility, which have more influence on memory than is thought. As we said, in beginning this chapter, one of the cases of amnesia that most struck us was that of a patient at the Havre hospital, whom we described by the name of Rose. She had in her remembrance an indisputable lacuna of three months' duration, which is unusual and indeed quite rare. Unlike the cases of the patients of whom we have just now spoken, it was not sufficient to hypnotise her in any kind of way, to recover her remembrances; but despite all our attempts, prolonged during six weeks, we could not succeed in making her recover the memory of that long period.[1] This woman presented, as it frequently

[1] It is well to say that I did not know then, as I do to-day, the use of automatic writing, which would probably have given me other results.

happens with very ill hystericals, a somnambulism very unstable, continually changing, with occasional spasms and small convulsive accidents. One day, as she was in one of those accidental somnambulic states, she said to us spontaneously: "You have often asked me what had happened to me in the months of August and September. Why could I not answer you? It was so simple. I know well now that I did this, that," etc.[1] The remembrance of the three forgotten months had entirely come back, as we could verify. As soon, however, as this somnambulic state changed, and the subject entered the waking state, or any other somnambulic state, those remembrances disappeared again completely. We tried to discover what there might be unusual in this state, and were struck with a discovery which we still think interesting. In this particular somnambulism, which brought back her remembrances, Rose suddenly recovered the tactile and muscular sensibility of her whole right side, while in all her other states she was continually an entire anæsthetic. On the other hand, thanks to some information we were fortunate to obtain, we were shown that Rose was sensitive on the right side and on the left hemianæsthetic during the whole period of those three months the remembrance of which had been lost. The accidental restoration, we confess, of the same state of sensibility had been accompanied by the restoration of all the remembrances of that period. Facts of this kind have, we think, been often pointed out. We shall especially recall the extraordinary observation of Louis V., which numerous authors have collaborated.[2] This celebrated patient presents five or six different personalities, or rather five or six different conditions of memory, each

[1] *Automatisme psychologique*, 1889, p. 94.

[2] H. Bourru et P. Durot, *Variations de la personalité*, 1888; especially p. 123 *et seq.* See in the same work a certain number of analogous obsevrations.

characterised by remembrances and determined amnesias. In each of these states of remembrance, he had a particular state of sensibility, and it was enough, when possible, to re-establish artificially such or such state of sensibility to cause immediately the corresponding state of memory to appear. We establish with this patient and with many others a close relation between the state of sensibility and the state of memory, such as we met in observing the somnambulic states of Rose.

We have tried to verify this relation experimentally by producing well-determined anæsthesias, and by seeking their influence on equally well-determined remembrances. We thus succeeded, we think, in establishing certain facts which do not seem to us devoid of interest. Very often,—we do not say always,—when an hysterical has completely lost a certain sensibility, she has at the same time lost the faculty of perceiving the images which depend on that sensibility. Thus, a patient whose observation we formerly recorded was attacked by a complete dyschromatopsia, and could not, with either one eye or the other, perceive any colour. It was therefore impossible for us to cause her to experience any colour-hallucination; she saw, she said, the flowers and objects we suggested to her for seeing, but she saw them grey and white.[1] She had at the disposal of her personal perception the images of the colours no longer than their sensations. Sometimes, also, we can make a verification in an inverse sense; if you suggest very strongly to a subject that he feels a certain tactile sensation, a kind of tickling, for example, in an anæsthetic member, the suggestion sometimes succeeds, and the subject complains of

[1] M. Paul Richer was the first, I believe, in calling attention to this phenomenon: *Études cliniques sur la grande hystérie*, 1885, p. 707; but he established his observation on a woman who was only achromatopsic in one eye, which makes the psychological interpretation more difficult. For a complete discussion of these experiments, see *Autom. psych.*, pp. 96 and 152.

being tickled. At this moment you can establish, by pinching the arm, that the tactile sensibility has wholly returned to that member. The image could not have been evoked without bringing back at the same time into the personal consciousness the sensation itself. These experiments may be varied indefinitely, and in most cases, you establish a sort of law of quite a regular application. The sensations and images of the same species seem assured; they are present or absent in the personal

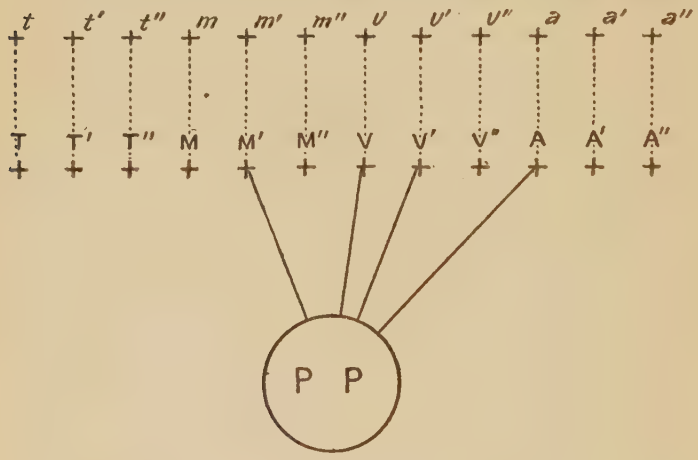

FIG. 7.

perception at the same time. If we take up again the schema which has already served, as Fig. 7, we can at each elementary sensation T T′ T″ M M′, etc., associate the corresponding images tactile t t′ t″, muscular m m′ m″, visual v v′ v″, and auditive a a′ a″, and we shall then read the graphic expression of the following fact: Personal perception, P P, when it seizes upon the sensations M′ V V′ A, is at the same time capable of seizing upon the associated images m′ v v′ a; on the contrary, by neglecting the sensations T T′ T″, it loses at the same time the images t t′ t″. In a word, certain amnesias seem to

be dependent on the anæsthesias. It would then be the abrupt variation of the state of sensibility that would determine the localised amnesias.

In certain cases, this explanation sums up the facts very exactly. The hysterical, unable, because of the retraction of the field of consciousness, continually to gather up in one and the same personal perception all the sensations and images, seems, in order to perceive them, to choose now the one, now the other. She has a very unstable personal perception. Ordinary men, says Professor Charcot, are auditives, visuals, or motors; some belong to the indifferent type. We think that it might perhaps be necessary to admit for hystericals one more type, the alternative type; for they pass naturally or artificially from one to the other; they are, for instance, visuals when awake, and motors when in the somnambulic state. A patient, Lucie, whom we formerly described,[1] answered absolutely this description: She naturally, according as she took to such or such type of thought, possessed or lost such or such category of remembrances.

However just these remarks may be in certain particular cases, we think they are far from solving entirely the problem of the localisation of amnesias. In fact, it is easy to understand that the disappearances and returns of remembrances take place usually in a much more complicated manner. The disappearance of a certain sensation and image may possibly not be the cause of all the forgetfulness which the preceding theory might indicate. Substitutes may present themselves; the same remembrance—that of a person, for instance, may be represented in the mind by images of a different nature, auditive images of the sound of voice, visual images of the face, etc. The name, alone, of this person may suffice to recall her to our mind when we have lost the visual image of her face, and very often the forgetfulness which any anæsthesia

[1] *Autom. psych.*, p. 104.

must bring about is compensated for and becomes somewhat manifest. On the other hand, certain images play, in our remembrances, too important a part. They serve in some sort as a rallying centre, around which all the other remembrances are co-ordinated, and the loss of those images, when it takes place, brings with it considerable amnesias, with little connection, apparently, with the anæsthesia that produced them. We may add, finally, that this association of the images and sensations, like that of the tactile sensations and movements, is an habitual association, very general, which, however, is not necessary, and which, in certain cases, may be broken; so it will be understood why we consider this explanation of amnesia as particular and limited to certain particular cases.

These studies on some particular forms of amnesia are, therefore, far from being complete, for the phenomenon is extremely complex and variable. They only confirm our general conclusion, explaining to us how personal perception, incapable of connecting all the elements with the whole personality, neglects perceiving such or such category of images. They show us that sometimes one may suspect why such a group of remembrances is especially overlooked; but they show us, also, that many complex and imperfectly known influences intervene to determine this choice.

CHAPTER III

ABULIAS

THIS word *abulia* (ἀ βουλή) designates, in a general way, the alterations, the diminutions of the will; it applies to laziness, to hesitation, to powerlessness in acts, as well as slowness, indecision, to the absence of attention to ideas. This characteristic is well known by the alienists, who observed it in many of their patients; among drunkards, for example, either through opium or alcohol; among delirious neurasthenics, and among patients suffering from melancholia. Certain patients, belonging to a group as yet imperfectly defined, seemed to be especially liable to that alteration of the mind which has been called "the folly of doubt." While recognising that this characteristic is really common to all these patients, we do not think it peculiar to them. Abulia, in all its forms, is one of the most common lesions in the weakening of the mind; it is for this reason that it is also established in hysteria.

We even think that this symptom plays a chief part in hysteria: first, because it is very general and intervenes more or less in many important phenomena, as, for instance, in suggestibility; then because its degree of gravity, more or less great, modifies greatly the prognosis of the disease. In order to show that this characteristic deserves to be considered a stigma of hysteria, we shall select, for study in this chapter, incontestable

hystericals presenting all the classic symptoms. The subjects of whom we shall speak are not only abulics; they are patients who have already been studied in the preceding chapters, and who have presented attacks, anæsthesias, amnesias — in short, all the classic symptoms. One, alone, of these patients might give rise to discussion—the woman, namely, whom we call Renée. For us she is an extremely interesting hysterical; but we see that neither her absent-mindedness, nor her tics, nor even her attacks have the classic form. If, now, the reader is a stickler for the diagnosis of hysteria, he may skip the few details we shall give on Renée. It will in no wise modify the general conclusions.

§ 1—DESCRIPTION AND CLASSIFICATION

Hystericals present themselves at first sight under two different aspects: some are restless, agitated, gay, like Margaret: others are calm, dreamy, melancholy, like Bertha—in fact, come nearest the type which has been called male hysteria, but which exists also in women. These two types need scarcely be differentiated. Hystericals of either type are no longer good for anything. They have lost all serious and useful activity. If you question the parents touching the beginning of the malady, the story is always the same: the first indication was that they could no longer do their work. M. Briquet had already noticed that his patients had entirely lost their love of work, and that the return of their activity was a sign of cure.[1] It is easy to verify this remark. This inertness, in fact, was extraordinary with Renée, who, for two years, had been unable to do any kind of work, even to sew a button on her dress, or write a letter to her parents: "Do not ask me such a thing," she would say; "the least bit of work appears to me an impossibility."

[1] Briquet, *op. cit.*, p. 22.

"I am willing to try," said another, Maz., "but as soon as I begin to work a little, it seems to me that I have been beaten all over the body." "I ask myself," said Bertha, "how people who work manage to do it." There are very few exceptions, that may be explained either by the fixed idea of earning a few pennies, as with Maria, or in an entirely automatic way of working, which we shall point out. This striking inertness of all these young girls, apparently robust, should not be considered only a trait of their personal character. We could not explain why hysteria attacks always inert people. On the other hand, it is easy to obtain information on this point and learn how these same young girls had been before extremely active. Among those we have just pointed out was a talented teacher; another, an excellent domestic; a third, a very industrious seamstress; and their former activity was appreciated by all who knew about them. It is since they are ill that they can no longer work, and their hysterical condition is the only cause of their inertness.

Work, except in some very rare cases of purely automatic work, is the greatest manifestation of voluntary activity, and if it disappears, the will with the hystericals must be at a very low ebb. An English physician, M. William Page, has expressed this fact in a very striking way: "The hysterical state," he says, "is essentially shown by the loss of control and the weakness of the will-power . . . the fault lies rather in the weakness of the will-power than in an obstinacy not to will. The patient often says: "I cannot"; but this means: "I cannot will."[1] "Hystericals," says also M. Huchard, "are excitable and led by their passions. All the

[1] The patient says, as all such patients do, "I can not"; it looks like "I will not," but it is "I cannot will."—W. Page, *Injuries of the spine and spinal cord without apparent mechanical lesion and nervous shock in their surgical and medico-legal aspects*, 1883.

various modes of their mental state may be summed up in the following words: They do not know; they cannot, and do not wish to will." [1] What these authors thus express, the patients say every moment in their own way. "I go, I come, I cry," says Margaret to us, "but without doing anything, without accomplishing anything, without willing; I am like a machine that has no longer any spring." This is what we designate in a general way by the word "abulia," and it is this characteristic the details of which we must analyse.

We may, in order to study abulias, adopt the division which has rendered us some service and distinguish systematised, localised, and general abulias. But we must observe, here, that, probably on account of our limited knowledge of this phenomenon, the first two groups are not well determined and are difficult to diagnose; the third group is alone important.

Systematised abulias are lack of will-power, bearing not on the ensemble of actions, but on a particular act or a system of special acts. Certainly such a lack of will-power is met with, and the suppressed acts are not always those which appear the most difficult to us. Renée, for example (we speak of her, because we think that in this case the question is of systematised abulias), ceases all at once to be able to speak or write. She can no longer say, "How do you do?" to a certain person, though quite able to greet all others.

But, in general, it is very difficult to diagnose systematised abulia with precision. In fact, when the question is of a determined action, we know that it can be suppressed in various ways. First, an action may be suppressed by a fixed idea opposed to it. When Isabella, in consequence of an attack during which she speaks of dying of hunger, refuses to eat, we should never think of

[1] M. Huchard, "État mental. mœurs des hystériques," *Archiv. de neurol.*, 1882, i., p. 203.

calling the phenomenon an abulia. But this is also an easily recognisable case. What is more embarrassing is that every action is a very complex psychological phenomenon and contains especially two principal parts—the will for an action and the performance of it. When an isolated act has passed from memory, it is not easy to say which of the two functions is impaired. It is the subject of the quarrel between the "no will" and the "no power" which has divided into two camps the authors who have studied abulia.[1] Certainly, these phenomena are closely related, and with the normal man they are almost wholly confounded. This confusion may also exist with the patient, and we may sometimes say with M. Féré: "The not-knowing, the not-willing, the not-being-able, are, in reality, equivalents of the psychical paralysis of motion."[2] But we are also obliged in certain cases to make a necessary distinction. An individual who knows what should be done, who represents to himself the act to be accomplished, but who cannot find in his mind the means of effecting it, who has simply *forgotten* the way of going about it, is not identical with the patient who does not give himself the trouble to conceive the act and makes no effort toward it. The one is simply amnesic, the other abulic. From a prognostic standpoint, it is no indifferent thing. As an example, astasia-abasia seems to us a form of amnesia of the motor images and not of abulia, properly so called. This distinction is particularly embarrassing when the question is of isolated actions. We think with M. Rivière,[3] that the *not-willing* is met with more frequently in the generalised abulias and the *not-being-able* in the systematic forms. This is equivalent to saying that the latter are generally amnesias.

However it be, some of these systematic abulias are

[1] D. J. Rivière, *Contribution à l'étude clinique des aboulies*, 1891, p. 11.
[2] Féré, *Sensation et mouvement*, 1887, p. 148.
[3] Rivière, *op. cit.*, p. 28.

interesting. Many patients cease for a while being able to speak, eat, or rise from their chair, or they can no longer make up their mind to fulfil the duties of their profession (professional powerlessness of Levillain). We shall dwell on only one of these cases, which greatly interested us and which, it seems to us, is more clearly connected with abulia than the others. We mean *the abulia of sleep.*

This expression seems odd, for the psychologists are not accustomed to consider sleep as an act, or to connect it in any way with the will. If you think of it, however, you will observe that will plays a great part in this phenomenon. Certain persons who enjoy a great power of will over themselves fall asleep when they wish, no matter at what time of day or night. Napoleon's celebrated phrase is well known: "When I wish to interrupt a certain affair, I shut up its drawer and open that of another. They do not mingle with each other, and never trouble or fatigue me. If I think I wish to sleep, I close all the drawers and am asleep."[1] Another remark may be added to the latter: Most of the old magnetisers, like Bertrand, Charpignon, Ordinaire, and especially General Noizet,[2] insist that sleep is suggested like any other act. M. Bernheim[3] has often reproduced this old observation and rightly so, for the fact is incontestable. This does not prove in any way that sleep may be confounded with somnambulism; all suggested phenomena are not necessarily confounded with each other; but it shows that sleep depends on our ideas as a kind of action. These remarks prepare us to understand a fact which we have very often noticed, namely, that sufferers from abulia do not know how to will sleep, nor do they know any better how to will to wake. Bertha, after having spent a whole day

[1] D'après Taine, *Régime moderne*, 1891, i., p. 25.

[2] Général Noizet, *Mémoires sur le somnambulisme*, 1854, p. 86.

[3] Bernheim, *Hypnotisme*, 1891, p. 72.

doing nothing, thinks of playing or asks herself if it is not time to work a little when the time comes round to go to sleep. When you scold her, she cries and says she will try to go to sleep, but she tries very badly and truly no longer knows how to become sleepy. When abulia increases with her—in consequence of fatigue, for instance—insomnia increases also at the very time when she should know how to sleep. She is put to sleep by suggestion, as we might say, but then again she cannot wake by herself, or half awakes and cannot make up her mind to be in one state or the other. This phenomenon is very frequent, and sleep is so serious a thing in nervous maladies that these few remarks on the systematised abulia of sleep will be excused.

We might employ the word *localised abulia* to designate several facts. Some subjects, like Margaret, experience states of momentary and periodical abulia during the day which precedes the attacks; her ideas get all mixed up; she can no longer will anything or pay attention to anything. Although she is always considerably abulic, she is not always so in the same degree. One might also say that abulia is sometimes localised not in certain actions, but in certain members of the subject. It is known that hystericals pay little attention to their anæsthetic members, that they almost completely forget them, and consequently cannot move them voluntarily as they would sensitive members. These troubles of motion need separate study. Lastly, it may be observed that the lack of synthesis, a characteristic of abulia, does not bear equally on all psychological images. Marcelle, a great abulic patient who remains to be studied, unites better and understands better the auditive images than the visual images, and the latter better than the images of the muscular sense. The study of these localised abulias is not yet sufficiently advanced.

The *general abulias*, which bear simultaneously on all

actions and thoughts, are much more important; they present themselves under two aspects nearly always united, which may yet be separated by description: *motor abulias* and *intellectual abulias.* To understand a malady, Professor Charcot often said you must study it under its clearest, its most typical form. We have been able to study with M. Falret an hysterical patient whose predominant symptom was an extraordinary abulia. We do not pretend to say that all abulias are fashioned on this model, but think that it will be well to reproduce this description before studying cases less serious and clear.

The most apparent fact to be first of all established with this person, and the first symptom she complains of when you question her, is a singular difficulty of motion. She remains usually immovable on her chair, doing mechanically some crochet-work, and refuses almost always to get up or make any movement whatsoever. When she is told to lift her arm or to stretch out her hand to take something lying on the table which she is bidden to reach after, she refuses with a displeased and pouting mien. If the matter is for some time much insisted on, she rises slowly, advances a little, putting out her hand, then stops, remains immovable, and says, "Indeed, I cannot," and withdraws her arm. She makes next a new effort, however; puts out her hand again toward the table, and with a sudden motion snatches up the object, not without having repeatedly put it down again, as if she could not make up her mind to keep it in her hand. These shilly-shally movements to take a penholder or a glass from the table may last a quarter of an hour or more, but generally Marcelle gives up before that. After a few fruitless efforts to do better, she withdraws her hand and refuses to move it again. "I cannot; there is no use to try." This is her way when she is alone. She can never go to bed by herself—needs some one to help her

undress. She touches her garments with a strange hesitation, scarcely succeeds in taking them off, and when you think they are off you see them put on again, and the whole thing has to be done over. One day we found her empty-handed; her usual occupation, her crochet-work, was lying on a table a yard away from her. "Oh, how tedious it is to be without my crochet! Please hand it to me." Another day we find her shut up in the hall and reprove her for not going out in such beautiful sunshine. "I tried," she said, "but not being able to do so, I kept still on my chair." This hesitation reaches the movements of the legs also, and, indeed, at certain moments, she remains silent when you speak to her and says afterwards that she could not open her mouth. She tried, she says, but did not succeed. In a word, all voluntary movements of the arms, legs, tongue, and lips present the same hesitation and the same powerlessness.

This hesitation and this powerlessness, which cannot be explained by any paralysis, cannot here be attributed to a fixed idea, such as might be, for instance, the thought of repugnant or dangerous objects. Let us examine the reasons which, in this case, as in others, permit the diagnosis of the motor abulia and a veritable delirium of touch.

We surprised Marcelle several times in her worst moments of hesitation, and asked her whether she experienced a real feeling of disgust that caused her to act in that way. She said no; and as we insisted she assured us that she did not at all know whence her hesitation came. The delirium of contact is usually limited (at least when in its primitive state) to a few objects that have struck the patient's imagination — door-knobs, or shiny copper things, pins, some piece of furniture or other, etc. Now Marcelle herself complains that people accuse her falsely, saying that she is afraid of door-knobs. Her hesitation has nothing to do with doors or

door-knobs; it is general, and applies to all objects without distinction.

A little experience may also help to settle the question. The authors who have written about the delirium of contact seem not to distinguish sufficiently, in their observations, two kinds of contact—the active and the passive contact. It is necessary, we think, in the delirium of touch, to establish the alteration of these two kinds of touches. The patient must not only be himself unable to touch the object, but also fear its contact when brought close to him. Marcelle never seemed to show the least fear of the passive contact. She never comes near enough to touch our hand, and she hesitates for an indefinite time; but she does not stir and does not seem displeased if we take her hand ourself. She cannot herself touch the paper, but she does not withdraw and does not complain if we place the paper on her hands. She often asks even for the objects she hesitates to touch. Contact, therefore, is not disagreeable to her and there is no real dislike. The trouble is in the active contact, the fact of making a motion to reach the objects. But, in this phenomenon, the principal element is the movement itself, and the contact here is not in question.

What makes the observation still clearer is that the same difficulty may be determined in the movements alone, isolated from all contact. Marcelle hesitates to rise, to walk, to speak, as well as to take anything into her hand. You induce the same efforts, the same hesitations, by asking her simply to raise her arms. We are, then, truly facing a psychological trouble that bears on the motor faculty, on the phenomena presiding over movements.

Such is the form of the motor abulia, when it is complete; generally it does not exist to this extent. Voluntary acts only become painful, slow, of short duration, and interrupted with innumerable delays. The patients

take an unconscionable time to dress, to eat, to sew a few stitches, or write the simplest letter. They experience especially a great pain in coming to a decision and in beginning a new work, and, very often, this difficult resolution is of no use to them; for one of the most easily established characteristics is, that they never finish what they begin. Their resolution does not last; at the first obstacle, at the least incident, their minds are diverted, they give themselves wholly up to a new thought, and completely abandon the first. "I made such a fine resolution," says Bertha, if you reprove her, "but what would you have?—some one came in and made way with it." To succeed in doing anything at all, these persons are obliged to divide and subdivide acts which to us appear very simple. They will make a first effort to-day to look for a needle; to-morrow they will make a second, to look for some thread; perhaps on the day after to-morrow they will begin to sew. They divide their actions into bits,[1] and, with all that, never succeed in performing the least complex act.

Intellectual abulia.—It is impossible to study nervous diseases and mental maladies without being well informed on this important characteristic. Not only has the will a motor action; it plays an essential rôle in the intelligence, and we are even disposed to believe with MM. Wundt[2] and Bastian,[3] that this intellectual function is the first, and that its acts are only its outer manifestation. Considered from this point of view, the will takes the name of attention, and its principal result is to make us comprehend, by synthetising them, the inferior psychological phenomena, inferior sensations, and images—to give us,

[1] Raymond et Arnaud, "Sur certains cas d'aboulie," *Annales medico-psychologiques*, 1892, ii., p. 79.

[2] Wundt, *Psychologie physiologique*, trad., 1886, ii., p. 444.

[3] Bastian, "Les processus nerveux dans l'attention et la volition," *Revue philosophique*, 1892, i., p. 353.

in short, the intelligence of things. This form of the will, like the other form, is disturbed in those subject to abulia, and the two alterations are usually simultaneous.

The difficulty of attention was already pointed out, in the oldest observations on abulia, by Leuret, in 1834, by Billod, in 1843, and by all the other more recent writers. A physician of Amsterdam, called M. Guge,[1] having observed analogous modifications of attention in the course of certain nasal affections, gave them the name of aprosexia (ἀ προσέχειν, attach oneself to, be attentive); the word seemed to fit and has even been applied to the troubles of attention in nervous diseases. We shall first study, according to rule, the most complete form of aprosexia, then describe the less pronounced forms which are here particularly interesting.

"One day," said Saint Thérèsa,[2] "I happened to read the life of a saint, . . . and I read four or five times in succession a few lines without being able to understand a word, although they were written in the common tongue. I threw the book down. The same thing happened to me a number of times. . . ." The hystericals of to-day do not fail to follow in this respect, as in many others, the example of their illustrious patroness. It is, in fact, by asking them to read attentively a few lines and then to explain how they understood them, that their aprosexia, in simple cases, is best determined. The way Marcelle reads a newspaper is a curious spectacle for a psychologist. We point out a paragraph for her to read. She obeys and seems to read all to herself. "I have read it," she says. "Well, what is it you read? What is it about?" "Indeed, I don't know; let me read it over again." She reads it over to herself as before. "Well, what do you make of it?" She stands surprised: "I do not know what to make of it; it does

[1] D'après Rivière, *op. cit.*, p. 21.

[2] Sainte Thérèse, *Autobiographie*, p. 184.

not get into my head." "Read it aloud." She reads aloud and very correctly, although monotonously; but when she has done, the result is the same; she has understood nothing. She reads French, her mother tongue, as if it were a foreign tongue. She pronounces the words clearly and understands each separately, but the sense of the paragraph escapes her wholly.[1]

Yet there is no lack of sensations in her, since she reads correctly aloud. Is it a trouble of memory? Most authors who describe analogous facts seem to suppose so, and say that the patient forgets the beginning of the phrase when she reads the end. This is an implied admission that with most abulics it is a form of amnesia continuous and extraordinary. With Mme. D., perhaps, the phenomenon might be of this kind; but we know that Marcelle forgets recent events after only a few hours. Besides, experience proves that it is not so. Once, immediately after her reading aloud, we asked her about the words contained in a couple of lines. She was able to recite them nearly all, but without understanding the sense of the phrase. This recitation of mere words is not in the order of reading, but seems to take place according to the order of common associations. She recites together words of a like consonance or nature. One day she read a small paragraph concerning a conflagration, which contained a number of figures—the date, the number of burned houses, the number of victims. She recited in sequence and without a mistake all the figures contained in the paragraph, but without understanding what they meant. We see that this intellectual alteration is due to neither sensation, nor memory, nor to the association of ideas as understood in the ordinary sense. There is here a particular defect of attention, the mechanism of which we shall study along with abulia. The

[1] "Étude sur un cas d'aboulie et d'idées fixes," *Revue philosophique*, 1891, i., p. 389.

same characteristic lack of intelligence in reading is observable in other patients, quite regularly in Maria through the space of a whole year; more irregularly in Bertha, Justine, and many other patients.

If aprosexia increases, this lack of intelligence will show itself not only in the complicated phenomena of reading but in the simple perception of outward objects. One day Marcelle's parents came to see her, and it was thought that permission to leave the house to take a walk with them in the park of the Salpêtrière might please her. She went, but after a short time she was brought back. She was no sooner out of the building she was familiar with than she was at sea; looked all round in a frightened way: "Where am I? What is all this?" She refused to go on, looked on the ground and tried it as if to test its solidity. She recognised nothing around her; not a tree nor a bench, and finally declared that she was blind. When at last she was back in her accustomed ward, she grew calm and recognised its various belongings.

At another time Marcelle, being quite ill and attacked with delirious notions, showed us a similar trouble, not in the perception of visual images, but in the perception of auditive sensations. She appeared to listen to what was said to her, but laughed and kept on asking: "What is it? I do not understand." It was so; she did not understand a single word. We have observed similar cases, more or less brief, in many hystericals. Bertha, for whole weeks, is unable to understand what is said to her; she finds a place away from her companions. "I try in vain to listen to them," she says; "I cannot understand them and must appear so stupid." We have to repeat to her the simplest things a number of times and attract her attention. "It will not enter my head; it is too hard a head; I do not understand you and it worries me." There are patients with whom one cannot talk easily except when the cure is advancing. M. Séglas noticed

this fact in treating a hysterical of this kind.[1] If this aprosexia were to remain permanent to that degree it could be said that the patient would pass from hysteria into another class of disease,—melancholia, for example. This evolution, as we shall show later on, is not so rare as people think; we can see here how natural it is. When aprosexia is complete, as in the preceding cases, it presents a particular character. The patient is generally calm, indifferent to his disease; he does not appear to be in pain when told to fix his attention; the fact is that he really does not fix it at all. Things will not go on in this way in less marked aprosexia. When the power of attention is simply diminished instead of being suppressed, a number of very complex disturbances may be observed:

1. Attention is very *slow* and very difficult to fix; every moment the subject escapes you and begins either to dream or to babble at random. You have to excite her and encourage her again and for a long time that she may try to pay attention. It lasts much longer when she is alone. When Margaret is about to write a letter she has to take several days to make ready for it. "Indeed, I must set about it; must catch up with time."

2. When the attention is somewhat fixed and the subject really tries to understand what is put before her in the way of reading or ciphering, then all sorts of *sufferings* begin. Anxiety from all sides, very severe headaches often, headaches which sometimes persist and interrupt the patient's movements. The patient, who fears these pains, avoids spontaneously the exercise of her attention, or exercises it only in indispensable cases. A young man of this class, who was frequently guilty of uncalled-for diversions of attention, told us: "When I am with intimate friends I do not think it worth while to pay attention; I just let myself go."

[1] Séglas, "Faits de thérapeutique suggestive," *Archives de neurol.*, 1885, *extrait*, p. 11.

3. These subjective phenomena, which occur during the exercise of attention, are accompanied by objectively appreciable symptoms, new *anæsthesias*, and *disturbances of movement*, which show plainly the difficulty of the effort. In order to give her attention to a thing, the hysterical is obliged to use all of her small amount of mental force, and for the moment sacrifice all the rest. She ceases perceiving the sensations she had conserved. Margaret, who usually is anæsthetic only on the right side, becomes so on both sides; Maria, Justine, etc., lose all sensibility likewise. You may put sulphide of carbon under the nose without their smelling it, though usually they push it away. The visual field contracts and can no longer receive any image except the one the subject is looking at.[1] Not only are the sensations, but the movements themselves, neglected by the subject. While the attention is fixed, it would seem as if the motor images had recovered all their independence. Then you see a great number of grimaces, tics, jerks of arms and limbs, of which the subject is not aware. You can take the direction of these movements, their lead, so to say, and make them execute a variety of motions of which the patient has no consciousness. For instance, that young man, a hospital inmate, who was suffering from echolalia while he was playing cards, his comrades caused to say all sorts of things without his knowing it. It is the principle of a variety of subconscious acts, which we shall study farther on.

4. This very painful attention does not last long; it oscillates, ceases, returns for a moment, and ends after a variable time, always sufficiently short, by disappearing completely. It brings often in its wake a certain number of *accidents*. Some subjects just turn their eyes away from their work and say that they cannot continue, complaining of a severe headache. With others it is a more

[1] This point has been studied in regard to the visual sense, p. 71.

serious matter: such great exhaustion takes place that they can no longer do anything, nor feel anything, for quite a while. Justine fixes her eyes on a book and tries to read; she reads two minutes, then complains, rubs her eyes, which smart, she says, and water; she tries again, but sees no longer anything; she is entirely in the dark. This blindness, however, lasts only a few minutes, and the patient begins to read again. After a little while the same manœuvre is repeated. It is a part of the phenomenon called *asthenopia*, but we think that here it is simply central and depends on the fatigue of attention. Justine, like many of these patients, reads often without any attention, thinking of something else, and understanding absolutely nothing of what she is reading. This kind of reading does not tire the eyes, nor do they become blinded.

The same exhaustion may become manifest not in the senses, but in the intelligence itself. Marcelle had just awakened from a somnambulic sleep, and was enjoying one of her lucid intervals. Her moral state was remarkably good, and, according to the preceding observations, she should have retained these qualities for half a day, at least. But, unfortunately, with that odd curiosity of hers, which supervened at this moment, she began to look at some papers that were lying on the table. She saw some sheets upon which we had drawn visual fields, and expressed the desire to know what all those little round things meant. We yielded, curious to see how a person of her kind would listen to a scientific explanation, and told her in the simplest way possible what a visual field is. To our great surprise, she understood very well, and made very correct remarks on the drawings before her. All this was very fine for her. She, however, soon stopped in the midst of a sentence, fixed her eyes on the ground, and was suddenly overcome with a spell of melancholy, with complete aprosexia, which

lasted till the next day. A little mental fatigue had in an instant destroyed all the progress so painfully obtained. These transformations of attention are, in fact, very frequent. You ask Maria to give her attention to something—a newspaper article, for instance. She can scarcely make up her mind to it, but still she begins, proceeds slowly, and suddenly stops in a complete immobility, her eyes fixed on her reading. You think her attention is absorbed, but it is not so; she is in one of her customary crises; one of her fixities, as she calls them. There should be no time lost in shaking her out of this state, otherwise, in a few minutes, you can no longer get her out of it. We shall, farther on, give the psychological description of these states. They are automatic reveries, which supervene as a result of the total exhaustion of voluntary attention. Maria comes out of it uttering a deep sigh, and naturally having completely forgotten what she has just read.

This case calls for another well-known remark—namely, that many hystericals, when you wish to enlist their attention to something, have to be put to sleep (a somnambulic sleep). We cannot study this fact here before having spoken about somnambulism. We shall for the present remark only that prolonged attention destroyed the normal personality and permitted the automatic development of another form of psychological existence.

In short, we must not forget those hystericals to whom the effort of attention causes simply an attack, like Celestine or Renée. To make Renée remember what she formerly knew as teacher, we gave her a small problem in arithmetic to solve. She accepted with pleasure, remembering what interest she used to take in such things, and, indeed, she did not begin the task badly, only she finished it badly. After the lapse of five minutes, she jumped up of a sudden, threw herself on the floor, cried, "Miaou, oua, oua," and launched at me from

her very rich repertory of abuse a goodly number of insults. This was the psychological result of a problem in algebra. We understand now an observation which we gathered with surprise at M. Séglas's consultation. A little boy was sent to him from school because he had convulsions every time he was trying to pay attention. The fact may be verified with a great number of patients, and belongs to the categories of the preceding cases.

5. Now, what are the *results* of this difficulty of attention? They are not very remarkable. The patients who have not a complete aprosexia succeed finally in understanding. They form ideas relative to the things; but these ideas are ill-formed; they lack clearness and stability; they are imperfectly possessed by the subject, who allows them every moment to escape. Hence this big symptom of the state of mental hysteria, as is proved by all enfeebled minds—namely, doubt. Doubt is not the term properly applied to doubters who, besides, are very often simple hystericals. It exists with the most classical hystericals.

This doubt may bear on present perceptions. If you present to Marcelle certain objects,—a book, a knife,—asking her what it is, she cannot on certain days determine their nature with any certitude. "I believe it is a book, but I may be mistaken . . . come now, tell me, is it a book?" One day she was present at a small concert, and she put to herself anxiously the most singular question: "Is all this true? This music, these people who dance; it does not seem true; it must be a dream."[1] Bertha one day meets her brother, who comes to see her, and looks at him hesitatingly: "Is that really you? I am not sure I recognise you." "I have always," she said to us, "a kind of veil before my eyes; a fog; shall I not some day pierce it? All that I hear seems to drop from a great void; I lose myself in my ideas as in a net,

[1] "Aboulie et idées fixes," *loc. cit.*, p. 387.

as a poor fly might in a cobweb." Doubt may also bear, and that oftener still, on remembrances and imaginations. Patients represent to themselves the past badly, and the future equally so; they doubt what they have done and what they are going to do, and even the stories they themselves tell. One may understand what singular and complicated perturbations may result from it. One doubts about the past, and will have false remorses; another has imaginary fears; one accuses everybody of lying, and another accuses herself of lying continuously. It would take volumes bearing especially on doubt to describe all these facts.

We should not like, however, to conclude this study, summing up aprosexia, without noticing a curious detail which is observable in these cases of insufficient attention. When Bertha reads and tries to pay attention, she stops over a word and looks at it surprised: "See now! the word '*house*.' What a *funny* word! We call by this word the places where we live! What a *funny* notion to call them this way! See again, 'a year,' what a *funny* thing! we count by years; why should we count by years?" Louise, a little girl of thirteen, hysterical, has similar astonishment for every object she looks at attentively: "A bed! how *funny!* I did not dare to call it so at home; they would have laughed at me; but when I returned from boarding-school, I found furniture, chairs, a clock, so, so *strange!*" Maria stops before a tree, a plant, any kind of an object: "How big a tree is! how green boxwood is!" etc. This phenomenon is frequent. We think it has its importance, for this astonishment is the starting-point of a series of questions, and when the patients are predisposed to obsessions, they get thus into the folly of interrogation — what the Germans call "*Grübelsucht.*" We have repeatedly, on examining a patient attacked by this delirium, found, in the beginning of her interrogations, the initial astonishment of

Bertha: "One day, when I was very tired," said one of them to us, "I saw a stranger enter, and he looked so funny to me! Since that I always ask myself, why do men have noses?" There is, perhaps, at bottom of this delirium a disturbance of attention analogous to that of the hysterical.

This characteristic, "funny," "strange," consists simply, we think, in an impression of "novelty." It is a feeling of "never seen" in opposition to the illusion of memory of "already seen." We experience this feeling ourselves when we look at an object under an unaccustomed aspect,—when we look, for example, very closely at the pupil of an eye. Our patients see badly, and connect very badly their sensations with their remembrances. Hence this defect of *recognition*, which is added to the already numerous disturbances of their intelligence of things.

We could only enumerate them briefly in this chapter. Each of them would require a special study. What has been seen suffices to show the importance of those troubles of the intellectual will in hysteria.

§ 2—PSYCHOLOGICAL ANALYSIS AND INTERPRETATION

It would be easy to show, in the abulias of the hystericals, the same psychological characteristics which have been pointed out in the study of their anæsthesias and amnesias. But as these characteristics are now known, we think it will be better to present things from a somewhat different standpoint and bring out a few traits which existed already in the other stigmata, but which are here much more manifest.

In fact, it is easily seen that this abulia is equally variable and mobile. Vel. recovers all her energy when she is drunk with alcohol or ether; for this reason she has so strongly partaken of this means of refreshment. It has

also been established that very often this symptom presents a contradictory aspect.

When we study a typical case, like that of Marcelle, one will always be struck, as we ourselves have been, by the opposition between the words and the acts of the patient. Marcelle declares herself unable to budge, to make the least motion, to rise from her chair, to take hold of an object, and she makes before us most fruitless efforts to lift a finger. However, if you seem to go away, and look at her without her being aware of it, especially without her being able to think that you observe her, you will discover that she really moves about a great deal, and that she performs most of the movements she declared herself incapable of performing. Here, again, as in the preceding studies, you must not conclude too quickly that the patient has deceived us, and that just for her amusement she had caused herself to be shut up in a ward of lunatics. We must remember that movements may be performed in various ways, and that one of the ways of moving might have been lost while others were maintained.

The first characteristic of abulia may be summed up thus: It is the *conservation of former acts.*

We think we should first of all recognise a vast category of movements and actions which exist without modification despite the general enfeeblement of the will. (1) Physiological movements, respiratory, digestive, etc., have never changed. (2) The reflexes are altogether normal of knees, eyes, mouth. Marcelle coughs, winks, etc. (3) The movements which, by exercise, have become instinctive, are also intact; she moves on her chair, changes position, drives a fly from her face, scratches herself, blows her nose, without a shadow of hesitation. (4) The same with habitual movements. She does some needlework and has on hand a piece of crochet-work, which remains ever the same, an interminable strip of

lace. (5) To these various categories of conserved movements it were well to add others more strange. She sometimes scribbles indefinitely on a bit of paper, or bites her nails, or she starts as in a frenzy to carry out some unreasonable purpose or other. But then she does not hesitate. She who stops before a door for half an hour, unable to open it, opens it quickly as in a fit of fury when she is in the spirit of these impulsive acts. These various movements are equally conserved, and with still greater reason with other patients less seriously attacked than Marcelle.

What is their common characteristic? We may say without hesitation that they are *automatic* acts. Only this word ought to be precisely defined, and we shall insist on one of the principal characteristics of psychological automatism. All these conserved acts are *old* acts, not executed for the first time to-day. As an act assumes such a character it becomes more and more easy. We were trying one day to exercise Marcelle in voluntary movements. We scattered on a table a variety of small objects and requested she should hand them to us one after the other. She consented readily to this kind of game and meant to do well. Now, despite her good will, she did not altogether succeed. Of certain objects she took a pretty good hold, of others not. There was on the table a piece of crochet-work, her own, which we had taken from her work-basket, and a pencil of mine. She managed to take her crochet after a couple of minutes' hesitation only, but it took her ten minutes and often a quarter of an hour to take the pencil. This game was repeated several times, and we noticed that she improved. But we saw, too, that while she had learned to take her crochet and our pencil, it was enough for us to replace our pencil with another one to call forth again all the great hesitations of her abulia. In a word, she had succeeded in taking hold of a customary and well-known

object, but could not take hold of anything new which she had not touched before. This characteristic is found with all patients who, during their period of abulia, continue with their former actions unless complications arise which make these acts more difficult to perform.

It is the same with the intelligence of ideas. The aprosexias continue to understand the things they once understood. We know that Marcelle and Maria—for experiments on the latter were resumed and the results proved the same—can never succeed in understanding a newspaper paragraph read for the first time. We gave Marcelle a few lines in a journal to read—the marriage announcement of a well-known personage, and description of the ceremony. We read it aloud to her first and tried to make her understand what it was about. As she understands the spoken word more easily, especially ours, she finally got hold of the meaning. The next day we made her read another paragraph, but to no purpose; it was all dark to her. Then, without preparing her, we put before her eyes the paragraph already explained to her, and understood the day before. She read it aloud and exclaimed, quite proudly: "Oh! this is about the marriage of Mr. X. and the ceremony in the church. See how well I understand now!" We repeated this little experiment for several days. No article whatsoever, of but two lines even, was understood, but when she read *her article*, already laboriously explained to her, she triumphed without suspecting the reason of her understanding it so well.[1]

We were pleased to see that M. Séglas, in his very interesting book on the troubles of language, adopted this explanation entirely. "They cannot understand reading nor remember recent facts unless the synthesis of them be once given to them."[2] In a word, all that has

[1] "Aboulie et idées fixes," *loc. cit.*, p. 390.

[2] Séglas, *Les troubles du langage chez les aliénés*, 1892, p. 28.

been acquired once remains acquired, and just as an amnesic like Mme. D. remembers all her past life, so abulics repeat and understand their former actions and ideas.

The second characteristic of abulia will be the loss of new acts.

Lost actions are, by opposition, called *voluntary* actions. Without entirely analysing this difficult term, we already know a first characteristic of the voluntary acts, namely, new acts. Not only does Marcelle with difficulty take hold of a new object, but she finds herself powerless in all the acts where any novelty comes in. She is wholly unable to talk with an unknown person. It took her two months to learn to speak to us. She now speaks to us with perfect ease. We took her one day into another office of observations, where she had not yet been with us. On the threshold she was taken by an interminable crisis of abulia, although she had always followed us readily into our customary office of consultation. This characteristic may still be seen in the way in which she walks. If once she has started upon a certain line, she goes on hurriedly, but let any obstacle present itself, or, rather, let her be called and be obliged to change the line started on, and she will stand still, without being able to make up her mind to start anew. It is always the beginning of the act, the start, that is painful. It is necessary, however, to understand what we mean here by the beginning of an act. It is not the material fact of putting in motion muscles which are in repose. This fact exists the same whether a pencil or a paper-cutter is to be taken from the table. We mean the formation of that complex ensemble of ideas and images by means of which it is necessary to represent to oneself the act of laying hold of a particular object. This synthesis is not exactly the same for one object as for another, and it is this synthesis, on her part, which is difficult with

Marcelle, while the repetition of this same synthesis, when already made, is easy.

Automatic acts are acts for which it is sufficient to repeat a former synthesis of images. In a word, acts formerly already willed—for will, understood here by its suppression, is the formation of these new syntheses. An act is voluntary only when new.

The same remark applies evidently to the intelligence of ideas, and the facts which we have analysed give the experimental explanation of a general remark often made concerning the character of abulic patients. "They have the strongest antipathy to new ideas; they will not learn anything new."[1] Here again it is not so much the complexity of the synthesis as its novelty which suppresses perception. When this synthesis has once been made, no matter by what process, it repeats itself automatically. The elements need no longer to be bound together; they are so already; the question is no longer of a synthesis, but of an association of ideas; and abulics, as is known, perform them quite well without hesitation and without doubt.

The first remarks raise some difficulties we must try to solve. If you tell an abulic to go and find some object which she has never handled before, she does not remain absolutely immovable. She will rise, put out her arms, etc. She succeeds, in a word, in making some of the necessary movements toward complying with the request. This is because this act is not entirely new. It is composed of a collection of former acts which she can easily perform.

Another cause of surprise is that these patients not only begin acts with difficulty, but that they have equal trouble in continuing them and that they show themselves so little persevering. There are particular cases

[1] Raymond et Arnaud, "Quelques cas d'aboulie," *Ann. méd. psych.*, 1892, ii., p. 74.

in which the act may be continued, in remaining always the same, and then the patients continue it only too well. But, as a general thing, an act lasts only by being incessantly modified, by its being adapted to circumstances continually new. There is an effort of repeated creation oftener required for the continuation of an act than for its beginning.

Why, it will be asked again, does Marcelle, on certain days of serious illness, as she has but too often done, completely stop and even lose the power to perform her most habitual acts? She no longer knows how to speak to us, although she has spoken to us a hundred times; she no longer knows how to dress herself, to rise from her chair, etc. We shall answer with a paradox, perhaps—a paradox to which the psychologists have not given sufficient attention, but which the clinique of mental maladies brings sufficiently out here. It is that there is no act wholly old that does not contain a small portion of novelty. To rise from our chair to-day is not exactly the same thing it was yesterday. The time, the temperature, the outward circumstances, the state of mind and body, are no longer exactly the same. Even to speak to a very well-known person is always an action that is in some respects new. The person to whom you speak—her costume, her physiognomy, the subject of the discourse—all that changes. "One never bathes twice in the same water," said the old sage. The universe changes incessantly, and whatever be the apparent identity of the circumstances in which we are placed, there is always a change, either without or within ourselves; a change which demands a new adaptation on our part, a new effort. Since the future is never the exact repetition of the past, a conscious act is never completely automatic. We must always make some effort, invent, even exert, our will somewhat, to perform the most habitual act: and when Marcelle's will goes down to a degree really

too low, we are not the least surprised to see her unable to perform even her habitual acts.

We may consider the conservation of the subconscious acts and the loss of the personal perception of the acts, as the third characteristic of abulia.

Whatever be the truth of the preceding remarks, they are not sufficient to interpret abulia completely. You may see the patient in various circumstances do things very easily, and yet these acts seem to be new—as new, at least, as certain others previously thought impossible. The best example of these embarrassing cases may be furnished by experiments of suggestion. If we request one of these persons gently, politely, to do a certain thing, to take a paper-knife from the table, she replies, "Willingly," and prepares to do so—tries, but it is not done. If, on the contrary, while she talks with someone else, we suggest to her in a whisper to do it, she does it immediately. In the same way we tell her to stop working, to take her work up again—to rise, to walk, to pick up something, etc. She performs all these movements without knowing it, but, note, she performs them without hesitation. We know that Bertha can no longer go to sleep of her own accord. Through a suggestion given at the right moment you can procure for her immediately the most calm and prolonged sleep. We had formerly prepared an experiment which made this opposition very palpable. We suggested to Marcelle, while in a somnambulic state, that, at a given signal, a blow on the table, she should take my hat and hang it on a peg. This done, and apparently forgotten when she woke, we said to her softly: "Mlle. Marcelle, we wish you would take our hat away from here and hang it on a peg." "Certainly," she said. She tries to get up, gives herself a shake, puts out her arms, makes a few inco-ordinate movements, and sits down again, recommencing the same fruitless attempts. We let her work on that way for twenty min-

utes without her having been able to make the least progress towards the accomplishment of this simple act. Then we strike a blow on the table. All at once she rises quickly, takes the hat, hangs it on the peg, and comes back to sit down. The thing was done by suggestion in an instant; it could not be done by her will in twenty minutes.

How do we explain this difference ? The two acts, despite appearances, are not absolutely similar from a psychological point of view. In the first place, the voluntary act is evidently far more complex. When Marcelle is about taking the hat of her own accord, she knows that it is a hat, that it belongs to us, that in such or such circumstance she takes it to oblige us, etc. If she takes the same object by suggestion, the act is done quickly and without reflecting. She does not even know what she has in her hand as we stop her on her way; she does not know why she took the thing. In a word, the synthesis of all the variable outward circumstances which constituted, as has been seen, the new side of the act, exists only in the act done voluntarily. This synthesis either does not exist or exists much less in the suggested act, which becomes simpler, more identical with former actions of the same kind and, consequently, more easy.

But there is a much more important observation to be made, which is now easy to understand, thanks to the studies on hysterical anæsthesia and amnesia. Let us stop Marcelle in the midst of a suggested act and ask her what she is doing. She answers, all abashed: " I have not done anything." " Why, you have just now taken this hat." " No, it is not I that took it." And she will always repeat the same answer when questioned on an act of this kind. Truly, the suggested act, so well performed, is with all these patients an isolated, subconscious act, in no wise connected with the personality of the subject.

We think that observation of the patients will permit us to generalise this remark. It will be seen that what disappears, with the abulics, is the possibility of acting consciously, of connecting their acts with their present personality. A young man, a student in medicine, of whom we have related some case of absent-mindedness, was dining one day with one of his chiefs, an eminent surgeon. He spoke, during the dinner, of various things, and only toward the end noticed that his host was curiously eying him and smiling. "I asked myself," said he, relating the fact, "what M. X. could find in me out of the way. I thought of my conversation; all I had said seemed reasonable to me. I examined my attire; it was all right. Yet M. X. kept on smiling. I then bethought myself of *listening to my last phrase*. . . . I had been *thou*ing him for an hour." This way of speaking without listening to oneself, of acting without feeling oneself act, without having a personal consciousness of it, was accidental with this young man; with some patients it is constant.

Maria works a great deal, and regularly, to earn a few pennies. This is surprising in an hysterical person; but as soon as you examine her you will discover that she never knows what she is doing. Her mind is elsewhere or nowhere, but her hands sew without her being conscious of it. The fact is especially observable in Bertha, who is sufficiently intelligent to have herself noticed the strange way in which she worked, complaining of it:

It is incomprehensible what is happening to me,—she said, when she first came into the hospital;—I work so strangely for some time; it is not I that work, it is only my hands. They do very well indeed, but not because of me. When it is done I do not recognise my work at all; I only see that it is well done, but I consider myself wholly incapable of doing such work. . . . If anyone should say to me: "You have not done that," I should reply: "You are right; I have not done it."

. . . When I want to sing, I find it impossible, and yet at times, listening to myself, feeling my lips move, I think that I sing such or such a song very well. . . . Surely it is not I that am walking; I am like a balloon, bouncing around all alone. . . . When I want to write, I find that I have nothing to say; my head is empty, I must let my hand write what it pleases; it thus fills four pages; I cannot help it if it is all absurd trash; when I figure up any sum, I write down the amount, but I know very well that it is not I that find it. . . . My ideas are no longer comprehensible to myself; they come of themselves; one might say that they are written on a big roll which unrolls before me. . . . I am nothing more than a puppet held by a string; *everything leaves me;* I am here only to stand for something.

What is most curious is that with all this she makes very pretty things. Whether it is a costume she is making, or writing a letter, she displays sometimes real talent, yet everything is done in that unaccountable way. She seems bent on her work, but does not appear conscious of it. When she raises her head she looks abashed, as if she came out of a dream, and does not remember what she has been doing. Her proceedings remind us of those attributed to people of genius who obey inspiration without being themselves conscious of what they are accomplishing. Moreau of Tours would not have rejected this comparison of the man of genius with the hysterical. To make a humbler comparison, our patient acts as we do ourselves at times, when we let our hand write alone the spelling of a word which we cannot recall; but what with us is accidental is with her perpetual. Although she is still active she has no longer the personal consciousness of her activity, and consequently can no longer act voluntarily.[1]

M. Séglas reported at the congress of the alienists of

[1] Conférence sur la suggestibilité des hystériques, *Archives de neurol.*, November, 1892.

Blois[1] an example of the same kind—a young man of nineteen, hysterical, and presenting the same state of automatic activity during the few days that preceded an attack. "It seems to me," writes the patient then, "that there are two persons in me; one that acts, walks, talks, only as if it were someone else, and another who looks on. . . ." It is a patient with whom the abulia is on the increase before the attack, as has been seen with Margaret; but it is still the same state which may be called the diminution of the personal perception of the acts with conservation of automatic activity.

This way of proceeding, when it is possible, diminishes the effects of abulia, since in reality the acts are always sufficiently performed. Other patients, on the contrary, will not or cannot abandon themselves to this automatic activity; they endeavour to perform the acts consciously and voluntarily, and then they do nothing more. They even prevent, by trying to perform them voluntarily, acts which would have been very well performed automatically. "The familiar movements, those which repetition has rendered automatic, are affected in their turn. They become again conscious and voluntary; they lose, together with the benefit of habit, the character of facility and rapidity which they had acquired."[2] The same trouble of the personal perception of the acts manifests itself outwardly, according to cases, by a greater or less powerlessness.

How is this new symptom of abulia, with all its characteristics, to be connected with the stigmata previously described? A small observation of detail will, perhaps, furnish us the necessary transition. An hysterical said to us at a ball at the Salpêtrière: "I cannot see the costumes; I have not seen one yet." "How is that?" "Because they keep me dancing. I no sooner want to look

[1] Congrès des aliénistes, Troisieme Session (Blois). *Archives de neurol.*, 1892, ii., p. 321.

[2] Raymond et Arnaud, *op. cit.*, p. 27.

than I stop dancing, and as soon as I dance I can no longer look. When I have a mind to dance I see nothing; I have but one thought—dance." We had, however, already seen that same characteristic, for we had been obliged to forbid her talking while eating. When she wants to eat, she must not think of anything else.

There is, then, a mental contraction for acts, as there is for sensations and images. The diminution of the synthetic power intervenes to modify actions as it does to transform sensibility and memory. New acts, adapted to variable and complex circumstances, require a synthesis more delicate and actual; they are the first attacked. Old acts, which are due to old syntheses and which are repeated at the present time almost without any modification, are scarcely altered. But, whether the one or the other is in question, the alteration bears especially upon a phenomenon which is necessarily always an actual synthesis, since it has to form itself anew at each moment of life—namely, the *personal perception of acts;* the assimilation of new actions to the great notion of the former personality. This lesion is the fundamental lesion of the hysterical mind. It is a characteristic of hysteria. If we established in a patient an abulia of this kind with the three preceding characteristics, and especially with the disaggregation of consciousness, even if this person presented no other stigmata we should nevertheless say that she is an hysterical. There are, in fact, monosymptomatic hysterias in the moral as in the physical domain. Just as Professor Charcot did not hesitate to consider Mme. D.'s amnesia hysterical, so we should call hysterical abulia a malady of the will which presents exactly analogous characteristics.

§ 3—CONSEQUENCES OF ABULIA

The consequences of abulia would be innumerable, were we to examine them all in detail. We think, in fact, that

most hysterical accidents depend on the pathological suggestibility of these patients, and that suggestibility is largely a result of abulia. But these phenomena are studied separately,[1] and it is enough to indicate here some general consequences which cannot be considered accidents and which are part of the ordinary mental state of hystericals. This feebleness of the will and of attention is, in fact, manifested by a second characteristic, which seems the inverse of the preceding and which nevertheless is its very logical consequence. Just as hystericals are incapable of beginning an action, starting a belief, or a perception, so are they equally incapable of stopping any when once started. To stop an action is to change our general state. It is to adapt ourselves in another manner to new circumstances. These patients, who understand no change, understand still less such an one, for it is necessary to create a clear and powerful thought in order to stop the automatic development of an old thought that has become stronger and stronger through repetition.

As Professor Charcot often said, most hysterical accidents are in the beginning almost voluntary. We begin to dream because we wish to do so; reverie is so pleasant. We begin to eat sparingly in order to be thin; to have a small waist and not to look like mamma; we begin an annoyance, get into tantrums, but we were "provoked to it." All this, and the patients will themselves confess to it, might have been very easily stopped at the beginning; but the act continues more and more automatically, and the patient can no longer stop it herself; it becomes a delirium, an anorexia, an attack. "When I have begun something," we heard a patient say, "I must go on with it; I cannot stop; I would break the windows; kill myself. . . . I am pushed on by my idea; driven in a way that I cannot resist." "I fall into an idea as down

[1] In the second volume of this work, which will especially treat of the "mental accidents of hysteria."

a precipice," said Bertha to us, "and the declivity makes it hard to get back again."

This inability to stop shows itself in daily observations. You know those patients who come to you every morning with an arm or leg contractured, asking you to "undo that" for them. There is hardly anything to undo, but this trifle they will never be able to correct alone. They will often come, too, when they have confidence in you, to ask for a moral help of the same kind. Margaret, one morning, came to say: "Oh, dear! I have been so angry all morning! I should like to beat somebody, break something! I had better stop right here, but I cannot; do rid me of this feeling." Another said: "I am out with my friend. I have been pouting since yesterday. It is such a wearisome thing, this pouting; I want to stop it, but cannot; do rid me of it." So we must cure one of anger, another of pouting, a third of dreaming; that is, we must help their ever-sinking will to stop a thing or begin one when necessary.

Patients, as we see, are always looking for assistance, and that is again an essential feature of the mental state of abulias. All those who have had to do with hystericals have also soon noticed that peculiar manner of theirs, quite characteristic of their disease, although it may also be found in other mental maladies—namely, their extraordinary attachment to their physician. The doctor that attends them is no longer an ordinary man. He assumes a preponderating position, against which no other influence can prevail. For him they will do everything; for they have once for all made up their mind to obey him blindly; they think of him all the time and regulate their whole conduct after that thought. But in return they are extremely exacting; they claim him altogether, are jealous of his interest in others, make constant calls upon him, want him to stay with them, and take it really to heart if he shows the least indifference.

This attachment, which develops according to the treatment they require, reaches extraordinary proportions if somnambulism and suggestion become part of it. The old magnetisers, who had often, though without knowing it, hystericals in charge, noticed it, and have repeatedly described this phenomenon. Perhaps we might, in honour of the heroic period of magnetism, call this attachment of the subject the somnambulic or magnetic passion. We intend soon to devote a detailed study to the magnetic passion, which is of ethical interest. For the present we will indicate here simply its essential points, important for the physician. He would, indeed, be a very superficial and coarse observer who would consider this passion from an erotic standpoint and connect it with vulgar and commonplace love-making. Hystericals, of course, may, like everybody else, have their own feelings of this kind; besides, there are not so many ways of expressing an attachment for another person, especially if that person be of the other sex. Certain subjects transform their attachment into a filial sentiment, into one of respect, of superstitious terror, or even into a maternal sentiment. One aged lady, a somnambulist, wanted us to look upon her as absolutely our mother. Shall we say that the magnetic passion becomes confounded with all these various sentiments? Truly it may exist without being accompanied by either the one or the other. An hysterical, a man of thirty, whom we had cured of a very troublesome tic, would not leave us any more, and came to see us on the slightest pretext, without having for us any kind of affection and without understanding himself why he wanted to see us. We have seen hystericals who had simultaneously a really erotic passion for one individual and a magnetic passion for another, and, without confusion, be equally engaged in rendezvous with the first and séances with the second. In short, without entering here into details, we

have known a somnambulist who, on a most trifling pretext, had always held us in horror. She had not the most common feeling of sympathy with us, yet she could not do without us, and, despite herself, was constantly obliged to come for us. We must in such cases avoid too sudden and puerile interpretations and recognise in the fact one of the most curious pathological sentiments.

In order to understand it thoroughly, we must consider the state of an hysterical when she comes to consult her physician—*her director*—and the state she is in when she leaves him. Margaret comes a long distance to the Salpêtrière. She finds she can no longer live the way she does; she is completely beside herself. She understands no longer what she sees nor what she hears; she doubts everything; the little incidents of her life rise before her and assume such importance that she puts to herself a host of questions and never succeeds in solving any; she has no longer any occupation, for she cannot make up her mind to anything. Justine presents another phase of hysteria. With her it is fixed ideas that trouble her; they get into her head, obsess her, prevent her thinking of practical things; she gets impulsively angry and fears the consequences of such fits of temper; she has completely abandoned her household and her husband. Maria thinks " in the air," as she says; she can hardly walk, her legs becoming paralysed; she goes every day to the morgue to see " the people that have had courage . . . etc." These patients go next to find some father confessor, and they come out of the confessional calm and cheered. Their many questions have been answered; some resolutions have been taken; their fixed ideas have disappeared.

What, then, has taken place ? The patients, whether hypnotised or not,—for everything depends, after all, on particular cases and subjects,—had the voluntary acts, which they did not do, done for them. Most of the little

problems of our daily life can be solved by a word, a "yes" or a "no," which we must say. Certainly, we may make a mistake in saying it; but a bad resolution is better than the complete absence of all resolution. These patients feel this and they simply beg you to say this "yes" or "no" for them. This done, they are quiet, for they think, then, that all is done, that life has come to a standstill, and that there will be no more new problems to be solved. It is their abulia that has created their imperious need of a conscience-director.[1] The magnetic passion of the hystericals is but a form of this general need of a foreign affirmation, which torments the doubters and all those whose mental synthesis is weakened. Certainly, there are yet in this need other phenomena more complex, into the study of which we cannot enter, for we do not purpose speaking here about therapeutics. We may, however, cause them to be understood by a comparison. Hystericals suffer not only from abulia, but also from the invasion of all automatic phenomena which they cannot stop. They might be compared to a king too feeble to govern his subjects. The greater part are in a constant state of rebellion. He is but too happy to meet with someone able to command the rebels, and he attaches himself to that person with all the tenacity of despair. The abulics feel that they are no longer masters of themselves and wish to be under command; they are voluntary slaves.

This domination may be favourable to the patient and allow him gradually to recover himself; it may also be very dangerous and prevent his final recovery. The study and treatment of hysteria require that we should never forget that this docility, this need of government, is a pathological characteristic of hystericals, with whose fundamental abulia it is connected.

[1] General Moizet had already proposed to call the magnetiser a "father-director." *Mémoires sur le somnambulisme*, 1854, p. 96.

These few details simply complete our summary description of the weakness of the will in hystericals. The resolution, rare and painful; the voluntary movements, slow and difficult; the attention reduced, powerless, and followed even by dangerous accidents; doubt and lack of intelligence for new ideas, coupled with irresistible impulses; monotonous continuation of habitual action; need of command and direction, hence exaggerated docility,—these are the characteristics, apparently varied, which all result from the same lesion of the mind. "The weakening or disappearance of the personal power," said M. Paulhan, "is always marked by the impossibility of a total co-ordination, of a systematisation which impels towards the same end both the new state and a sufficient portion of the tendencies which constitute the personality."[1] We think that we have shown in this chapter that the phenomena of abulia are connected with the general explanation of the other hysterical stigmata.

[1] Paulhan, *L'activité mentale et les éléments de l'esprit*, 1889, p. 178.

CHAPTER IV

THE MOTOR DISTURBANCES

DISORDERS in the limbs are in all mental diseases very numerous and very complex. Motion being, so to speak, but the outer manifestation, the expression of the thought is influenced by all the modifications of the latter. We shall in this chapter study only the simplest alterations of movement, those which might be considered as the direct consequences of the mental stigmata of hystericals. These elementary alterations exist almost constantly and, except in extreme cases, they are not very troublesome in the exercise of the normal functions, and rarely constitute accidents, properly so called.

§ 1—ENFEEBLEMENT OF THE VOLUNTARY MOVEMENT

Certain categories of movements remain almost normal with hystericals. The reflexes, for example, except those that depend on pain in cases of complete analgesia, are but little or not at all altered. Some authors, particularly M. Paul Richer,[1] claim that they are rather exaggerated than diminished. This is true in a great number of cases, but there is no regularity in it. It is difficult, for example, to examine the patellar reflex with Camille and especially with Renée. At one time, after the shock of the hammer, they each throw a leg

[1] Paul Richer, *Paralysies et contractures hystériques*, 1892, p. 25.

high up and even jump from their chair; at another, their legs remain nearly immovable. With some patients the reflexes run riot, so to speak; they lose their regularity and they change about incessantly, according to many phenomena, conscious or subconscious, which it is difficult to appreciate. We know, also, that the habitual and automatic movements are, in general, preserved and somewhat exaggerated. The important alterations of motion must, then, be looked for solely in the voluntary movements.

These movements present at first some general disturbances existing as well on the sensitive as on the insensitive side; they are simply exaggerated by anæsthesia; they are the first to be studied.

1. Voluntary movements are *slackened*, and the performance of the required movement takes a longer time than usual. It is useless to give figures when we treat of complex movements, since this slackening may take from a few seconds to half an hour, as we have established in Marcelle's case. This slackening is better observed in a special movement, the movement of reaction to a tactile impression. Even when they pretend to be good-natured about it, reaction with many hystericals takes a long time.

M. Féré has very often evidenced this fact, and has shown that the different parts of these times of reaction, the centripetal and centrifugal transmission, were equally retarded. This duration of the time of reaction seems to be in proportionate increase to the diminution of the general or special sensibility.[1]

A former experiment by M. Duchenne had already evidenced this slackening of the movements which characterises the less sensitive side of the patient. If you ask an hysterical to make with both hands the same movement at the same time, you will see that the insensitive

[1] Féré, "Les mouvements volontaires chez les hystériques," *Revue philosophique*, 1889, ii., p. 38.

hand is always retarded, and, despite the efforts of the subject, accomplishes always a less number of movements than the sensitive hand. But the direct measurements of M. Féré, then of M. Binet, have shown this retardation more explicitly. According to M. Binet, the average time of simple reaction would, for the sensitive hand, be 0.227, and for the less sensitive, 0.709.[1] Of course, the time of conscious and voluntary reaction on the entirely anæsthetic side cannot be examined. It is only a question of the diminutions of sensibility. In cases of hypoæsthesia, which, as we know, is due to a great absent-mindedness, we believe that the time of reaction may be still longer, especially if the subject's attention is not greatly excited. We have seen this retardation several times go beyond one and even two seconds, while the time of the simple reaction is generally maintained between one-eighth and one-fifth of a second.[2] Once, even, we observed with M. Sollier, on an hysterical man of M. Landouzy's service, a time-reaction which will appear quite incredible. It oscillated between twenty and thirty seconds. The reaction was so slow that it seemed no longer in relation with the excitation, and recalled the false perceptions of the ataxic patients. Of course, this time of reaction varies a great deal, as M. Féré often remarks, for it is in close relation with the subject's attention, and we know how feeble and unstable is the attention with the hysterical, especially feeble for all that concerns the anæsthetic side. Finally this slowness of the reaction brings with it a modification of the curve of the contraction, which ceases to be abrupt and becomes gradual. In the hysterical it has the same aspect which is produced in the normal man under the influence of fatigue.

[1] Binet, "Mouvements volontaires chez les hystériques," *Revue philosophique*, 1889, ii., p. 482.

[2] Wundt, *Psych. physiol.*, 1886, ii.. p. 251.

We have presented all these characteristics as psychological phenomena, in connection with the weakness of attention and the reduction of personal perception. In fact, one can induce, in consequence of a tactile excitation, on hypoæsthetic members, or even on members entirely anæsthetic, subconscious movements of which the subject is not aware. This experiment will permit us to calculate, not, indeed, the time of the conscious and voluntary reaction, but the time of the subconscious and automatic reaction. M. Onanoff, whose premature death we deplore, was the first to make on this problem a series of experiments, and he has demonstrated that if the time of the conscious reaction were slackened, it was not necessarily the same for the time of the subconscious reaction, which may, on the contrary, be very much diminished.[1] This fact shows that the retardation is not due to some modification in the elementary nervous apparatus, but to that modification of the superior centres which diminishes conscious attention.

2. The voluntary movements are *undecided* and ill-directed. It is enough to ask the patient to touch a small object, to thread a needle attentively, to establish this lack of precision. But this characteristic becomes curious and important when anæsthetic members are operated on, and when the subject is requested to turn his head away and act without looking. Tactile anæsthesia alone does not alter movement much and does not increase general indecision. Deep-seated muscular anæsthesia is much more important.

M. Duchenne[2] had already observed that certain subjects could move quite well without having the sensation called by M. Gerdy "sensation of muscular activity," or by M. Ch. Bell "the muscular sense." Professor Charcot insisted on this fact, and showed subjects

[1] Onanoff, *Arch. neurol.*, 1890, p. 372.

[2] Duchenne (de Boulogne), *Electrisation localisée*, p. 413.

who could not tell which were the passive movements impressed on their arm, and yet were able to move that arm without looking at it.[1] If we may trust our observations, the subjects of this kind are not all afflicted with a very complete kinæsthetic anæsthesia. They have lost the sense of motion in hand and arm, but they have retained it in the shoulder, and they move their arms like a sort of stick, of whose displacements they are vaguely conscious. Some, however, as Professor Charcot says, feel nothing at all, even in the shoulder. With these, still more than with the preceding ones, the motion is altogether disorderly, and justifies M. Duchenne's phrase, "the ataxia of hystericals." If you request them to touch their ear, they throw their arms about at haphazard, strike their neck or their head; they hold the objects you give them to hold badly, or squeeze them in a way to break them.[2]

The nature of this indecision is very clearly explained by an experiment which has been often made. "If the patient was told to put her hand to her ear, she would perform the motion immediately; but if my hand is interposed between hers and her ear, she would not be conscious of it. If I placed her arm on the bed without her being able to see it and told her to put her hand to her head, she would make the effort; then she would stop and keep still, thinking she had performed the movement."[3] It is thus seen that the phenomena, whatever they be, which precede the act—the will, namely, and the mental representation of the movement to be accomplished—are intact, but that the sensation of the accomplished movement which guides the subject and teaches him the performance of the movement no longer exists in his normal consciousness. In other words, the patient seems to have retained the faculty of representing to

[1] Charcot, *Leçons sur les maladies du système nerveux*, iii., appendice.
[2] Briquet, *op. cit.*, p. 298.
[3] Thèse de Deneaux.

himself the kinæsthetic images which induce movements, but, in return, to have lost that muscular sensation which teaches us how our movements are performed, and warns us of whatever resistance may be in the way.

This indecision is a consequence of hysterical anæsthesia. We can, in fact, see in this phenomenon all the characteristics of anæsthesia. If Maria or Isabella puts her hand to her ear consciously and voluntarily, the hand goes at hazard and strikes her hair; but if, by the processes already described, we induce the performance of this same act in a subconscious manner, the unconscious arm is raised and touches the ear directly. The indecision and "ataxia" of the movement exist, therefore, only in the personal and conscious act, as the anæsthesia was manifested only in the personal perception.

3. Voluntary movements are *simplified*;—by which is meant that the hysterical is no longer capable of executing complex acts, acts which necessitate simultaneously several *different* movements. The patient can consciously make but one movement at a time. This remark was formerly the gist of our work on psychological automatism. It has since been taken up by several authors. "When you request these patients," says M. Binet, "to make several movements simultaneously, all their attention is brought to bear on a single movement; . . . the subjects themselves note this point, and remark that it is very difficult for them, when they hold an object in both their hands, to bring them together to grasp it; they cannot think of both their hands at once."[1] In a more recent work, M. A. Pick, of Prague, has enlarged this general remark by a great number of details.[2] He

[1] Binet, "Les mouvements volontaires des hystériques, *Revue philos.*, 1889, ii., p. 470.

[2] A. Pick, Uber die sogennante "Conscience musculaire" (Duchenne), *Zeitschrift für Psych. und Physiol. der Sinnesorgane*, herausgegeben von H. Ebbinghaus und A. König, iv., 1892.

examines the movements of an hysterical whose visual field is much contracted and who is anæsthetic on the right. In order to study them he requires his patient to move the fingers of the right hand as if playing the piano. The movements are well performed if she is allowed to look at them while her right hand is moving its fingers. This is a condition the importance of which will be studied in the following paragraph. While thus engaged it will be enough to ask of the patient to perform another movement, be it ever so insignificant, to disturb or completely stop the movements of the fingers of the right hand. It is enough to bid her raise the left arm,[1] stretch out her leg, open the mouth, pronounce a few words, close an eye, etc. The movements of the right hand will immediately be altered or suppressed. This is an interesting detail which our previous studies will allow us to understand; the sensations induced in the mind of the subject will have exactly the same result. It is sufficient to prick the patient on the sensitive left side, to cause her to smell an odour, to place an object or a pair of coloured spectacles before her eye, and these impressions will take possession of a considerable portion of the attention she can dispose of and make the movements of the right hand altogether impossible. This fact is not due to the anæsthesia of the hand, for the things will occur in absolutely the same way in regard to the movements of the left hand, which is sensitive; these are also very much altered or suppressed by any other movement or simultaneous sensation.

M. Pick sums up his experiences by saying: "Besides the contraction of the field of consciousness, we should admit a *contraction* of the *motor impulsion;* it is for this reason that the motor impulsions do not develop simultaneously."[2] We believe that these two phenomena are absolutely identical. What M. Pick calls contraction of

[1] Pick, *op. cit.*, p. 181.

[2] Pick, *op. cit.*, p. 182.

the motor impulsion is, after all, but a reduction of the number of the kinæsthetic images or others which the subject may simultaneously bring together into the same personal perception; which he may, at a given moment, assimilate to his personality. Facts of this kind have been studied at length in respect to amnesia and abulia. We are happy to see that M. Pick has verified in so complete and interesting a manner the general hypothesis of the contraction of the field of consciousness in the hysterical.

4. Voluntary movements are *weakened*. This fact has already been noticed by M. Briquet,[1] who ingeniously compared it to the numbness produced by strong emotions. This interpretation seems to us exact in only one point, and that is, that the question here treats of a moral phenomenon. M. Burcq, Professor Charcot, then M. Paul Richer, have described that fact with great precision under the name of *amyosthenia*.[1] We are surprised to see a person of great muscular development shake your proffered hand with such little strength, or make so little resistance to the movements you communicate. If, for more precision, you were to employ a dynamometer, which you cause the subject to grasp, you would obtain some extremely small figures. This diminution happens to both hands, but it is much stronger on the anæsthetic side. Here are a few striking examples: Margaret, anæsthetic on the right side, obtains 8 on the right and 25 on the left. Bertha, anæsthetic on the left, gives us 25 on the right and 10 on the left. Camille, anæsthetic on the left, has 18 on the right and 3 on the left. Celestine, anæsthetic on both sides, has 9 on the right and 5 on the left. These figures indicate the average of numerous measures taken while the patients have their eyes open and can look at their hand as it tightens upon the dynamometer.

[1] Briquet, *op. cit.*, p. 442.

[1] Paul Richer, *op. cit.*, p. 23.

Although this phenomenon appears localised, it is no less the manifestation of the general state of the whole being,[1] and is evidently related to all the psychological facts already described. A few remarks will prove it. It is certain that the moral phenomena have an enormous influence on this muscular weakness. For instance, amyosthenia will increase if you diminish the attention of the subject—if you do not allow him to look at the hand that is clenching the dynamometer.[2] Margaret, with her eyes closed, has 0 on the right and 10 on the left; Bertha has no more than 15 on the right and 6 on the left; Camille, 9 on the right and 0 on the left; Celestine, 0 on the right and 0 on the left. The weakness will, on the contrary, disappear, if by every possible means you strongly excite the attention by making the patients look, showing them the movement and making them move the hand several times before it closes upon the instruments, etc.

We will add only a general remark to show the analogy of this fact to those that have been studied in the preceding chapters. These numbers, indicated by the dynamometer, appear to us altogether surprising, and we find that most authors accept them without manifesting sufficient surprise. If we give the dynamometer to hemiplegics, amyotrophics, to clasp, we also obtain numbers from 5 to 10. This would not surprise us, for we know quite well that we have to do with infirm persons whose weakness shows plainly in all their actions. But our hystericals, who number 5 and 10 by the dynamometer, are not, like them, infirm; they sew, they work, they carry packages, without any apparent difficulty. An example will explain our thought: Celestine is a robust country girl, accustomed to the roughest kind of work, who asks as a favour to be allowed to sweep, to scrub the floors,—a thing she does with the greatest

[1] Gilles de la Tourette, *op. cit.*, p. 456.

[2] Binet, *Mouvements volontaires chez les hystériques*, 1889, ii.

vigour. She is rough, and when things are not to her taste, she upsets the beds, changes their places, carries about with one arm heavy wooden arm-chairs. She has a bad temper and, in the asylums where she has been, she has mastered some very strong men. We stop that girl in the midst of her work, and give her the dynamometer to clasp. She is wholly anæsthetic on both sides of the body and clasps tightly the dynamometer, but only while looking at it. The instrument indicates as an average (the experiment has been made a number of times) 9 for the right and 5 for the left, even while looking at it. Now, we say that these numbers are in direct contradiction to what we see her do every instant. To assure ourselves fully of it, we made the trial, and, although we indicate 50 by the same dynamometer, we are incapable of lifting, as she does, arm-chairs and beds. The same fact may be established in a still more precise manner by experiment, but we must confess that then it is less striking. Margaret is absolutely anæsthetic on the right side, and if we ask her to clasp the dynamometer with her right hand without looking, she makes no motion and the instrument stops at 0. But it is known that we can induce in her subconscious movements with the right arm. If we make her thus clasp the dynamometer subconsciously with the right hand without her knowing it, the movement is real and marks 10 or 12. This is not much, and it may be noticed that all subconscious movements induced in this way remain feeble, but still 12 is more than 0.

There occurs, then, with the hysterical a special modification *when experimented on*, when you request her to pay attention, to clasp the instrument in a *voluntary* and *personal* manner so as to show *her own strength*. She can no longer recover it; she can no longer make use of it for such a purpose, although this force truly exists and is spent in countless acts of the current life of which the

patient does not take account. It is exactly the characteristic we have seen under the name of abulia.

This amyosthenia is then *en rapport* with the feebleness of the voluntary act. A former remark of M. Féré's can explain this dependency. He has shown that the dynamometric pressure, namely, the sudden and momentary effort, is weak with negroes, with workmen solely employed in manual labour, and that it becomes powerful only with men trained in the liberal professions. In a word, he has demonstrated that the greatest energy of the momentary effort coincided with the greatest activity of the intellectual functions.[1] This proposition appears inexact if applied to the force of any kind of movement; it is, however, just if its application is restricted to the power of the conscious and voluntary effort. If so, no one will be astonished to see the muscular power so feeble with hystericals, so feeble especially on their anæsthetic side. Their power of attention is next to nothing, and they do not know how to concentrate all their energies upon a momentary act. Their strength will vary automatically, according as the passions or habits will bring to bear on one and the same action psychological phenomena in a greater or lesser degree; but it will not depend upon them (passions or habits) to employ, at a given moment, this force in a conscious or voluntary manner.

All the phenomena which we have just studied may, then, be considered as moral phenomena. One of them, indecision and ataxia of movements, may be partly connected with anæsthesia, but all the others are immediate manifestations of the great defect of the will and conscious attention of abulia.

§ 2—LASÈGUE'S SYNDROME

Usually, when the members of an hysterical are attacked by an anæsthesia, quite complete, tactile, and

[1] Féré, *Sensation et mouvement*, 1887, p. 5.

muscular, affecting the entire limb, the troubles of motion are more emphasised than in the preceding cases. They take a very special aspect, one which raises some of the most interesting problems of psychology.

This alteration in the movement of the anæsthetic members was long ago pointed out by MM. Ch. Bell, Duchenne, and Briquet, but it seems to us that the most complete description of it, the most precise, was given by M. Lasègue,[1] and it is for this that we propose designating this ensemble of rather complex phenomena under the name of syndrome of Lasègue.

Let us first sum up the essential facts which constitute this syndrome.

1. The subject is incapable of effecting any movement on the anæsthetic side without the help of sight.

2. In certain experiments, the movement begun with the help of sight may be continued without this help.

3. Visual imaginations, or even the tactile sensation, may take the place of visual sensation, provided they teach the subject the position of his limb at the beginning of the movement.

4. This characteristic does not seem to trouble the subject, who, during his normal life, performs all the movements without any complaint.

5. If you raise the subject's arm without his seeing it, this arm will remain immovable in cataleptic postures.

6. Movements may be obtained without the help of sight, but they are subconscious, and the subject does not know of them.

We are going to study in this paragraph the first three characteristics which form the essential part of the syndrome, reserving for the following section the study of the other three.

The principal fact is the loss of motion without the help of sight.

[1] Lasègue, "Anesthésie et ataxie hystériques," *Études médicales*, ii., p. 25.

A mother nursing her child says M. Ch. Bell was paralytic; she had lost the muscular power of one side of the body and, at the same time, the sensibility of the other. This woman, a circumstance strange and truly alarming, could hold her babe to her breast with the arm which had retained its muscular power (but which was anæsthetic) only on condition of looking at her babe. If surrounding objects were to divert her mind from the position of her arm, her flexor muscles would gradually give way, and her child would be in danger of falling.

Another fact of the same kind has been often observed, namely, that anæsthetic patients cannot move during the night.[1] Lucy, for instance, during her periods of complete anæsthesias, could no longer make the slightest movement in her bed, when the light was out. She was in the morning in exactly the same position she had taken when lying down. A few physicians, M. Briquet [2] relates, had even taken this singular nocturnal paralysis for an intermittent malady and treated it with sulphate of quinine.

Such verifications are, however, very rare, for the fact we study here is a fact of experimentation. It has to be found before it can be established. It has been noticed that patients who are under observation, who watch themselves, so to say, while being examined, follow continually with their eye their anæsthetic arms or legs as soon as you request them to move. The act would naturally become simplified, it was thought, if that intervention of the visual sense was suppressed. We think, however, that we should avoid closing completely the eyes of the subject, for we may thereby induce with hystericals all kinds of alterations of consciousness, sometimes even somnambulic states.[3] Anæsthesia might be modi-

[1] Duchenne (de Boulogne), *op. cit.*, p. 420. [2] Briquet, *op. cit.*, p. 303.

[3] The alterations of consciousness and of movements induced by the closing of the eyes or ears will be studied in their place in the volume treating of somnambulism.

fied and the movements might not have any longer the same character. We must be satisfied with turning round the subject's head and concealing the arm with a screen. If we experiment in this way, we shall see that the anæsthetic member will be suddenly attacked with paralysis. It drops, flaccid, by its own weight, and no longer performs any of the movements required of the patient. The latter conducts herself, then, according as the case may be, in different ways. At one time she will seem to make powerless efforts, manifested by the expressions of the face and by the movements of her other side, which has remained sensitive, and say in a tone of despair: "I cannot. I do not know what the matter is; but I cannot raise my right arm." It is thus Margaret acts. At another time, as Maria or M. shows, the patient remains perfectly calm, and when you ask her to make a motion on her insensitive side, she replies: " It is done." Her arm has not moved. It is not always easy to account for these differences. The best we can do is to establish the principal fact: complete disappearance of voluntary movement if deprived of sight.[1]

This paralysis, caused by the suppression of sight, may be made manifest in various cases by more special details. You allow the subject to keep his eyes open and just place his anæsthetic hand behind his back. He is wholly powerless to withdraw it thence voluntarily (Bell's sign). When the subject is anæsthetic on both sides, you make him stand up, then request him to close his eyes; he will immediately stagger and completely collapse. Lucy, Celestine, Witm., Hab., and many others fall thus suddenly on the floor (Romberg's sign). Despite this fall and this flagging of the muscles, we must say, with M. Briquet, that this paralysis affects only the muscles of the members, and that neither the respiratory muscles,

[1] Voir aussi des faits de ce genre dans l'article de M. Raymond, *Revue de médecine*, 1891, p. 396.

nor the dorsal, nor the facial are, in general, attacked in the same way. M. Briquet observes very truly [1] that it is usually the muscles accessible to sight that seem to suffer from this suppression of the visual sense. However, we have pointed out cases [2] where patients, with their eyes closed, could not either open their mouth, or put out their tongue, or swallow. This exaggeration of the phenomenon is very rare. It comes near a fact of which we shall speak later in treating somnambulism, namely, the complete obnubilation which strikes the mind of certain hystericals when you close the only sense that can still act in a conscious manner.

M. A. Pick, in the work mentioned above, has studied the previous phenomenon at great length. He first shows, and on this point we are quite of his opinion, that we should not speak here of a real exhaustion produced by suppression of sight, nor of dynamogeny in consequence of visual excitations. The fact is, as has been seen, as well produced whether the subject has his eyes open or shut, provided his attention is in some way diverted. M. Pick wishes next to connect completely this motor powerlessness with a fact already pointed out in a preceding paragraph: the simplification of the movements in the hysterical. We know that an hysterical intent on making a certain movement, or maintaining a certain attitude, is unable at that moment to do anything else. Well, says this author, if I understood him correctly, the patient, in Lasègue's experiment, is intent on closing her eyes, on keeping her head averted, on looking at a screen, etc., and this is what prevents her raising her left arm. This motor powerlessness should, then, be connected with the absent-mindedness and contraction of the field of consciousness.

We quite like this interpretation, for we have always maintained that anæsthesia was a kind of absent-minded-

[1] Briquet, *op. cit.*, p. 478. [2] Pitres, *op. cit.*, i., p. 119.

ness, and that the troubles arising from anæsthesia might be considered as the consequences of absent-mindedness; but we must not forget that anæsthesia is a very particular form of absent-mindedness transformed by automatic habit, and that it has its special characteristics. Whatever be the general truth of M. Pick's remarks, there remains still a knotty fact—namely, that the subject averting his head, showing absent-mindedness, you will say, by his attitude, does none the less continue able to move on his sensitive side; he has lost the power of motion only on his insensitive side. Anæsthesia, then, adds something to the general absent-mindedness. The subject, although absent-minded, can move on his sensitive side without looking, but he is obliged to look to come out of his absent-mindedness, a much greater absent-mindedness when his insensitive side is in question.

Here is the explanation we formerly offered of these singular phenomena.[1] It does not seem to contradict M. Pick's; on the contrary, it appears only a little more complete. When hystericals are simply afflicted with muscular anæsthesia, their movements are hesitating, ill-directed, but, on the whole, remain possible. Unfortunately, anæsthesia carries with itself, as has been studied in the second chapter, a parallel amnesia. The anæsthetic subject who averts his eyes no longer feels his arm. Worse still, he forgets it; he can no longer think of it in any way. Not only does the patient no longer consciously feel the movements communicated to his arm, but he can no longer have consciousness of the kinæsthetic images, of the images of the former movements connected with this arm. He has become incapable of bringing into his personal consciousness the mental representation, under the form of kinæsthetic images, of the movement demanded of him. As the outward movement

[1] *Autom. psych.*, p. 350.

is but a manifestation of these images, he is incapable of actually producing this movement.

He is, therefore, truly paralysed by amnesia, and theoretically should be definitively and completely immobilised. But, fortunately, the mind has resources, and we can establish here the effects of a veritable psychological substitution. The sensations and the images of another sense, usually of the visual sense, help him to recover the thought of his left arm and to show him what movement he should make and how perform it.

Must we simply suppose that visual images serve as signal, as marked points (points de repère), to evoke kinæsthetic images which have become difficult to be evoked alone, but which reappear in the personal perception and take up again their motor rôle in regard to the visual sensations of movement? That, we think, is M. Pick's opinion.[1] It must be the case with many subjects. Margaret sees very well that the movement, when she does not look, is not really performed, since she makes an effort and groans at the failure. She is then at that moment not entirely deprived of kinæsthetic sensations, as she tries to evoke them more clearly.

But we are disposed to believe (this is a supposition which we express under every reservation) that it is not always so. Maria and M. have their eyes averted. We suggest to them only a *visual hallucination*—that, namely, of *seeing* their left arm lifting itself and placing itself before their noses. The hallucination develops, and they declare they see each her arm; but at the same time their arms had lifted themselves and really placed themselves before their noses.[2] They know nothing about it; they do not think that any movement has been performed; they do not care whether we stop or not the movement of their arms. In a word, they have, we believe, in their personal consciousness nothing more than

[1] Pick, *op. cit.*, p. 199.

[2] *Autom. psych.*, p. 148.

the visual hallucination of the movement of their arms, and, we repeat, this hallucination suffices to produce the movement. It is known that all psychological images have a motor side. It is known that every subject uses more particularly, for the things of practical life, such or such images. We do not hesitate to say that, from the standpoint of language, there are visuals, auditives, and motors. Professor Charcot, after having established the distinction of the diverse types of language, alludes also "to the individual varieties in the manner of performing the movements."[1] Why not admit that there are also visuals for the movements of arms and legs, or even for any movement separated from the others? The foregoing experiment succeeds with Léonie only if the hallucination of the particular image which, with this patient and at that moment, serves the movement, is evoked. With her the visual hallucination of the arm in motion, when her eyes are closed, provokes the movement on the left, the anæsthetic side, but does not provoke it on the right, the sensitive side. In order to bring about the movement of the right arm, the tactile and muscular hallucination of the displacement of this arm is required. It is an hallucination which is, moreover, unavailing, or even impossible for the left arm.[2] Have we not the right to suppose that at that moment she makes use, in order to move, of visual images on the left, and of kinæsthetic images on the right? Whatever be true in these discussions, which we no wise decide upon, but only offer here as a problem, one notion will remain unquestionable, namely, that the visual representation of the movement provokes or supplies the kinæsthetic representation of the movement that has been weakened or has disappeared.

It is this general interpretation we must verify by examining now the two following characteristics of the syndrome: M. Lasègue had already observed that subjects

[1] Charcot, *Mal. du syst. nerv.*, iii., p. 468. [2] *Autom. psych.*, p. 149.

like these do not need to see their anæsthetic member completely and freely. To move it it will be enough for them partially to discern it. "One of the patients has both her arms under the coverlet, which has been brought far up to her neck; yet, guided by the motions of the coverlet, which she watches, she can bring her arms out of the bed. The same with her legs, which she moves under the covering provided that she may see the eider-down, placed over them, move." [1] Maria, who is generally unable to do this, moved one evening her left arm very well without looking at it; we were surprised at this. It was because she followed on the wall the shadow of her arm projected by a lamp. A little visual sensation, then, is enough to serve as a starting-point for the whole visual representation. But let us go farther: M. Pitres [2] has made a very curious remark. The patient may continue keeping his eyes shut; the movement he began with his eyes open he can stop; but when he has let his arms drop, he can no longer begin again another movement unless he keep his eyes open and look at his members. The fact certainly is not very general. Some subjects have so little visual memory that they forget their arm the moment they no longer see it; yet this remark may be frequently verified. It seems to show that the visual image of the beginning of the movement is here the most important. We have repeated all these facts with variations. It is sufficient for Maria to look well at her hand lying in her lap, before she closes her eyes, to retain, for some time at least, the faculty of moving it. But now we stop her movement without letting her see where her hand drops; or, again, we displace her arm without telling her, and put it on her head; she has felt nothing of this; she thinks her arm is on her knees, or rather she no longer knows where it is, and says that she has lost it. We ask her then to put her hand out to us; but her arm can no

[1] Lasègue, *op. cit.*, ii., p. 39. [2] Pitres, *op. cit.*, i., p. 117.

longer move; or shows but inco-ordinate tremblings. Still better, without touching her arm, we make her believe that we displace it; that is enough for her not knowing any more where it is, and telling us in an anxious tone: "Do let me look and I will give you my hand"[1] In a word, *the important visual notion is the notion of the position of the arm at the moment of beginning a movement.*

We may then interpret a very pretty experiment of M. Lasègue's, reproduced by M. Pitres. It suffices to put the left hand of the subject upon any part of the body that is still sensitive, and he will be able to move it. The initial sensation which allows him to represent to himself the movement and to execute it is here borrowed from the tactile sense. M. Raymond[2] quotes from M. Strümpell and from M. Heine a case rarer still. The subject, in order to guide his insensitive hand, struck repeatedly on the table or on his head. It was this time the auditive sense that served to evoke the motor image. All the facts agree to show the importance of this supplemental representation which allows the conscious performance of a movement, notwithstanding the disappearance of the true kinæsthetic images which are no longer a part of the field of consciousness.

These combinations and these substitutions of images, which are the consequence of the anæsthesias, often give rise to strange phenomena, which may be considered as abnormal varieties of M. Lasègue's syndrome.

1. *Synkinesia.*—Léonie is anæsthetic on the left side. Her eyes are closed, and we ask her to raise her right arm; she raises it correctly; we ask her to raise her left arm; she raises *both arms together*. She does not leave the left arm immovable, as the previous patients do; she moves it well and even makes, without looking at them, the most exact finger movements, yet only when all symmetrical movements are simultaneously made with

[1] *Autom. psych.*, p. 352.

[2] Raymond, *op. cit.*, p. 585.

the right arm. Formerly we put this fact aside because we did not understand it. We have since seen facts of synesthesia, which have been described in the first chapter, and we believe that this is a fact of the same kind, which may be explained in the same manner. We do not return to this principle. The sensations and images of the symmetrical portions of the body are almost identical; it must be the same with the movements. The motor images of the symmetrical movements must be almost identical and must be very easily confounded. With Léonie these motor images are clear and isolated for the right arm; the same motor images are confused for the left arm, and are in an inseparable manner confounded with the symmetrical images of the right arm.

It is probably for this same reason that M. Pitres's patient could, with closed eyes, put both her arms in the position of the boxer, and could not raise the left arm separately;[1] and it is for this reason also that M. Féré noted with his subjects a marked tendency toward associated movements, which movements became stronger and more rapid than isolated movements.[2]

This confusion may present itself in another way without our being able to say what produces the modification. M., in the periods when she presents what we have called simple allochiria, confounds the movements as well as the sensations of the symmetrical parts. When we tell her to raise her right or left hand, she hesitates and tries to take her bearing by looking at the hand that has a ring. Without this, she raises her hands at random, sometimes both, but generally one or the other indifferently.[3] It has been several years since she can distinguish the move-

[1] Pitres, *op. cit.*, i., p. 118.

[2] Féré, "Les mouvements volontaires," *Revue philosophique*, 1889, i., p. 64, and "La gaucherie acquise", *Revue scientifique*, 1889, ii., p. 606.

[3] "Une alteration de la faculté de localiser les sensations", *Revue philosophique*, 1890, i., p. 659.

ments of the right and the left side, and she commits strange blunders which have been noticed by several persons. It even seems that at an earlier period she felt very unhappy about it and would begin to cry when people would tell her the road, saying, "Turn to the right," "Open the door to your left," for she did not understand what they meant, and would get completely lost. To-day she is somewhat cleverer and gets along by means of a few processes of which we have already had some examples. The question is still of an incomplete amnesia, which removes the very delicate and characteristic signs of the symmetrical images.

2. *Allokinesia.*—The same patient, as has been seen, has periods of complete allochiria. She presents at the same time a regular allokinesia. Now, when she is told to raise her right arm, she does not any more hesitate, and makes the movement immediately, but it is always made with the left hand, and *vice versa*. We do not repeat the explanation which we have already given once regarding this phenomenon, at least as far as it is possible. We insist only on one point, namely, that this passage of a motor phenomenon from one side of the body to the other happens frequently to the hysterical patient. A trembling, a paralysis, a contracture, as well as an anæsthesia, reappear on the left side when we have worked very hard to undo them on the right side.[1] We have often proved this without the use of magnet or metals, without any suggestion, without either the operator or the subject's having thought of this very disagreeable incident. There are psychological laws which connect symmetrical phenomena and which substitute some for others. To change a phenomenon from one side to another is for an hysterical the slightest change possible, the one she will most easily make, automatically, as soon as the equilibrium of her consciousness is modified. Of

[1] Gilles de la Tourette, *op. cit.*, p. 216.

course, there are transfers[1] operated through pure and simple suggestion, but there are others to which the foregoing laws apply, and which are indirectly connected with Lasègue's syndrome.

3. *Heterokinesia.*—We think we may give this name to a very curious case described by M. Briquet[2]: "The muscles [of an anæsthetic member of an hysterical whose eyes are closed] perform movements exactly contrary to those she has in mind. Thus, when the patient thinks of closing her hand, the latter opens; if she wishes to make a motion of extension, it is a flexion movement that is being produced." We regret very much never having had an opportunity to observe this phenomenon. We have seen a great number of cases of the same kind in the thoughts and sentiments, but have not been able to study the phenomenon in its simple form in movements. There must be here, as we saw previously, a confusion of images which, from a certain side, resemble each other. Contrast, we know, presupposes a great resemblance. The question is ever regarding those incomplete distinctions and those irregular associations between badly observed phenomena.

In a word, Lasègue's syndrome, with its different varieties, has shown us some of the consequences of anæsthesia and amnesia, the troubles of motion they bring with them, and the phenomena of substitution, which succeed in re-establishing motion by giving it a particular aspect.

§ 3—PARTIAL CATALEPSIES

Lasègue's syndrome, which we may now define to be an ensemble of perturbations of movement which presents itself in a member completely anæsthetic when the patient can no longer look at it, is in reality composed of

[1] "Sur quelques phenomènes de transfert," *Autom. psych.*, p. 156.

[2] Briquet, *op. cit.*, pp. 301, 478.

negative and positive phenomena. The first phenomena show, in fact, that, under these circumstances, the movement is suppressed or can be performed only in very special ways. A second group of phenomena shows us, on the contrary, that, under the same circumstances, certain movements may be conserved. The preceding section presented the study of the first. We must study now the last characteristics of this syndrome.

One might believe, at first sight, that this singular need of always looking at one's members before being able to move them must be very much in the way of the patients, who must thus be obliged to look at their feet or hands before taking a step or making a gesture. This is not the case. M. Lasègue [1] wondered to see a patient of this kind working in a seamstress-shop, whose work was equal to that of all the other seamstresses. Margaret presents this syndrome in the highest degree on the right side. In the laboratory she is unable to move her foot, or even one of the fingers of her hand, without looking at it. In the yard, she walks very fast, eyes wide open; she catches any object you throw to her; she follows with her eyes the flying bird, and yet she walks very steadily and does not fall. Camille, when studied experimentally, is wholly unable to move her left arm without looking at it. The experiments once over, she talks with us and is not aware that we watch her left arm, which moves with perfect ease outside her field of vision.

Léonie has no power over her left arm when we place it behind her back; yet every morning she laces her corset, using her hands simultaneously or separately behind her back and has as good command over the one as the other. Finally, not all are like Lucy, immovable during the night. They move about, readjust their bed, or rise, notwithstanding complete darkness.

This special paralysis of anæsthetic members, not

[1] Lasègue, *Études médic.*, i., p. 904.

looked at by the patient, is, therefore, not absolutely continuous and does not affect all movements. It really acts like all stigmata and we must here also find out under what conditions the phenomena are conserved.

We may establish even experimentally this conservation of movements, for it shows itself in its simplest and most decisive manner in M. Lasègue's very curious phenomenon, which he describes under the name of *partial catalepsies*. We know very well this strange disposition which the members of a patient show during attacks of natural or induced cataleps.[1] If we touch the members, we observe that they are extremely mobile and, so to say, light; that they offer no resistance and that we may easily move them from one place to another. If we leave them in a new position they do not fall back to their old position, according to the laws of gravitation; they remain absolutely immovable in the place where we have left them. Arms, legs, may be put in any kind of position, even the strangest, and they will keep that position without modification. It is for this reason that these subjects have been quite naturally compared to painter's manikins, which may be adjusted in a number of ways.

The first authors who treated catalepsy noticed that this state may be only partial, that is, that it may exist only in a part of the subject's body, and that the rest may be engaged in a variety of acts and present wholly different characteristics. An arm, for instance, may act as if it were the arm of a person in a cataleptic state, while, in other respects, the subject, far from being in that state, laughs and talks as if he were unmindful of his arm.[2] M. Lasègue went farther. He showed that this phenomenon was not rare, that it was not a partial attack, but a normal characteristic of anæsthetic members which the subject does not look at. It has been seen that Mar-

[1] Paul Richer, *La grande hystérie*, 1885, pp. 283, 610.

[2] Saint-Bourdin, *Traité de catalepsie*, 1841, pp. 29, 59.

garet's right arm seems unable to effect any movement when she does not look at it, and that the muscles appear extremely flaccid; yet it is enough for us to take hold of her arm without her knowing it, and raise it up to whatsoever position, for that arm to remain immovable in that position and for the muscles so to contract that this member may maintain this attitude. When we touch the arm again we can very easily place it in a new position, where it will likewise remain.[1]

The most important character of these cataleptic positions is their persistency, their duration. The arm does not spontaneously change the position it has been put in; and if no one interferes and modifies it, it will keep it indefinitely. We have often seen such positions continue without any appreciable change for twenty minutes or half an hour. MM. Binet and Féré describe some that lasted an hour.[2] During all this while the arm does not oscillate, does not tremble, does not seem modified by fatigue. After a certain time, generally a quarter of an hour, in our experiments, the muscles are seen gradually to relax and the arm come slowly down, without any start, and preserving quite regularly its primitive attitude, until it is completely down, which takes quite a while. During this time the subject talks of something else, moves as he likes his other limbs, and has no thought about his outstretched arm. He hardly ever experiences any fatigue or discomfort. Sometimes he complains of feeling a painful tension in the muscles of his opposite, sensitive side. If you speak to him about his cataleptic member without allowing him to look at it, he will be wholly ignorant of where his arm is, or of what it does. He says that he has forgotten it, or may reply: "My arm? why, it must be quietly lying in my lap." If you next inform the subject that his arm is not

[1] *Autom. psych.*, p. 228.

[2] Binet et Féré, *Archives de physiologie*, 1 Oct., 1887.

in his lap, and request him to put it there again, he is unable to do so consciously and voluntarily, and cannot any more change these cataleptic positions, without looking, than he could previously move his arm, which hung down immovable. Lastly, if you allow him to turn his head and look at his arm raised in the air, he is astonished at what he sees and lowers it immediately. Now he can move his arm as he wishes, put it even in the previous position, but he will no longer keep it there in the same way. "The sensation of fatigue reappears at the same time with the sight's recovering its free activity. The patient gets as quickly tired as anyone else of the positions to which members within his sight are subjected." [1]

Such is the phenomenon under its typical form, and it may present many modifications and complications.

1. This partial catalepsy may be met with in other states than the normal waking state. When an hysterical is in a somnambulic state she retains sometimes her various anæsthesias, and her members obey in the same manner without her knowing it as when she is awake. We must not confound this partial catalepsy through anæsthesia during the somnambulic state with the state of total catalepsy, nor with the positions suggested to somnambulists, which they maintain consciously. The same phenomenon, we formerly insisted,[2] may be presented in three different ways. This state of partial catalepsy may also be observed in other circumstances more remarkable, as, for example, during an hysterical attack. When Rose is in a great hysterical crisis, no matter at what period, we can, so to say, take possession of an arm or a leg by touching it lightly. The member we have touched for a moment remains then inert and does not participate in the tremblings or convulsions of the rest of the body. If we raise it, it remains in the position in which we place it, or even, as will be seen presently, will

[1] Lasègue, *op. cit.*, ii., p. 40.

[2] *Autom. psych.*, p. 234.

repeat regularly the movements which we communicate to it. The attack has evidently modified the general attitude of the subject, since the other members continue their convulsions. It has not in itself changed the partial catalepsy.

2. This phenomenon may be increased. With certain subjects, especially with those who have been frequently hypnotised, it is enough to keep a member, ordinarily sensitive, raised in the air for a while, for it to become anæsthetic and cataleptic. Sometimes the change is even produced when the subject looks at his arm. Inversely, this phenomenon may suffer diminutions. In order to take place, the subject must not have in his consciousness any indication concerning the position given to his arm. If the tactile and muscular anæsthesia is not complete, the subject will lower his arm more or less easily. This is even the means of appreciating the degree of anæsthesia in certain subjects. M. presents usually the phenomenon of partial catalepsy, but on certain days it may be ascertained that the arms fall more or less quickly. This, as may be verified, is because the anæsthesia has diminished. If, in course of an experiment, we can succeed, by some kind of process, in restoring to the subject the muscular sensibility of his member for a little while, the cataleptic state will immediately disappear. It is also necessary that the subject have no indication whatsoever through the visual sense. The reflection in a mirror, a shadow, is sufficient for Maria to lower her arm. The visual imagination of the position of her arm suffices to enable Justine to recover gradually the possession of her members.

Finally, there is another very important condition, the absence of which will diminish or even totally suppress the phenomenon. With some patients this partial catalepsy becomes immediately manifest, whoever be the operator, provided he put himself into the proper

conditions. The anæsthetic arm is obedient to everyone. But things do not generally occur this way. You may try to lift Léonie's, Lucy's, or Maria's left arm without her being able to see it. The arm will not remain extended, and no cataleptic phenomenon will take place. Better still, when we ourselves have placed their arms in a cataleptic position, no one else can change them; their arms, so light but a moment ago, will resist with all their might. If you press them hard, they may yield a little, but as soon as they are free again, they will, as if through elasticity, regain their first positions. Let us touch them again, and they will suddenly become light and obey all impulsions.[1] This is a form of what is called electivity, the choice, namely, which the subject, without knowing it, seems to make of a special director and of that special domination which the director will exercise to the exclusion of all other persons, over the psychological phenomena of the patient. We should remember that electivity interferes greatly in partial catalepsy. This characteristic will serve as its interpretation.

3. Finally, this phenomenon may be more and more complicated. If you impress a movement on the arm instead of leaving it simply suspended, it will continue this movement indefinitely, with the regularity of a pendulum. This same movement may also be induced through imitation in a more indirect manner. Certain subjects repeat, without knowing it, and only with their anæsthetic members, the movements you make before them.[2] This imitation sometimes is wholly spontaneous, and is not the result of an experiment. Lately, speaking with Justine, we noticed that she had continually a regular movement of oscillation of the left arm, as a kind of tic. We asked her what she was doing; she answered that she was not moving at all, and, in fact, as soon as she looked

[1] "Actes inconscients," *Revue philosophique*, 1888, i., p. 248.

[2] *Autom. psych.*, p. 230.

at her arm, all stopped. A moment later, when she turned her head away, the movement began again, and we noticed then that her hand followed the motion of the clock's pendulum. We all have similar phenomena to show, but with anæsthetic hystericals they are remarkable for their frequency and their importance.

These attitudes and movements may also be determined in another way, namely, by the contact of an object put into the anæsthetic hand of the patient. We put on Lucy's arm, which, in this cataleptic state, is horizontally stretched out, a light pen; the hand holds it. We withdraw the pen and put in its place a two-pound weight. The arm does not bend under the much increased weight, but, on the contrary, the tension of the muscles adapts itself to the weight to be supported. If we put a pair of scissors in the insensible hand, the subject will not be able to tell us what she holds in her left hand, and yet her fingers have slipped into the scissors' rounds, and open and shut them alternately. Finally if you put a pencil into the hand, the fingers, as we have often noted, will unconsciously bend, and, without the subject's being aware, place themselves in the proper position to write. The hand even will often really write and then we enter a category of more complex phenomena.

The interpretation of these observations and others analogous would raise a great number of very interesting psychological discussions. We have tried to introduce them elsewhere and cannot reproduce them here. It will be sufficient to recall the conclusions. It does not seem possible to explain these facts by a purely physical mechanism without any intervention of mind. The arguments of M. Despine,[1] who is the principal representative of this conception, appear all questionable to us. The

[1] Despine, *Psychologie naturelle*, 1868, i., p. 490 *et seq.*; *Étude scientifique sur le somnambulisme*, 1880.

unity, the co-ordination of these muscular contractions, their complication, their unquestionable relation with tactile, auditive, or visual impressions, the electivity, the intelligence, in a word, so constantly manifested in them, appear to us, first of all, psychological phenomena. If there is no sensation, no thought connected with it, we do not understand how an arm can keep the delicate position we give it; can distinguish the touch of our hand, obey it, and not obey the touch of other hands; can repeat outward movements which can be known only by hearing or sight, etc. All these acts are conscious, the consequences of a sensation, of a vision, of a hearing, of a preference. Here it is the physical explanation that is mysterious and mystical; it is the psychological explanation which is the most acceptable, and the most scientific hypothesis.

But if the existence of these phenomena of consciousness is incontestable, their nature, on the contrary, is very difficult to conceive. We must not forget, in fact, that the person on whom all these experiments have been made expresses her opinion concerning the phenomena of partial catalepsy. She declares that she has felt absolutely nothing; that she has had no thought whatsoever on the subject, and that if she had had any, she would not have been able to manifest it, since she cannot move her arm without seeing it. We cannot doubt her word, because she declares only facts well known and admitted by us all. She simply tells us that she is anæsthetic on the left side and that she is suffering from Lasègue's syndrome, which we believe to be true. Well, we do not say that she lies; we say that she is mistaken and does not know it; we affirm this paradoxical notion, which now begins to find its way into psychology, and say that there are in the mind of this person psychological phenomena she is ignorant of. We shall quote here a passage of an already old psychologist, M. L. Dumont,

who elsewhere repeated on this point the ideas of M. Maine de Biran:

> The words consciousness and unconsciousness are at one time taken in a relative sense and at another in an absolute sense. We say, for instance, that a phenomenon is unconscious [in order to avoid confusion, we would rather say subconscious], to express the idea that the ego has no consciousness of it, but without affirming thereby that the phenomenon is not conscious in itself and on its own account. Physiology tends to establish that there is thus being accomplished in the human organism an immense number of conscious facts which, for the ego, are as if they belonged to other people.[1]

It is such phenomena that have already brought us to the supposition that there were in anæsthesia and amnesia contradictory characteristics to be explained. They are manifested now by outward movements, and their importance in the malady of hysteria will increase more and more.

These phenomena, while being psychological, have none the less, on the strength of their isolation, very special characteristics.[2] They are remarkably simple; they are not continually modified and arrested by other facts which might be confounded with them; they obey the three fundamental laws of the isolated psychical phenomena: (1) They are accompanied by an outward movement; (2) they last and persist so long as they are not superseded by another phenomenon; (3) they tend to develop and complete themselves. These three laws account, we think, for the characteristics that have been recognised in partial catalepsy; for the attitudes, the continuation of movement, the adaptations to outward circumstances. One point alone might embarrass us,

[1] L. Dumont, *Théorie scientifique de la sensibilité*, 1877, p. 102.

[2] *Autom. psych.*, p. 66.

namely, the extended prolongation of similar phenomena and the absence of the feeling of fatigue. If we cannot wholly explain this detail, at least we can bring it within a more general problem: the disappearance of pain in anæsthesias. As a general thing, there is no subconscious pain, probably because these subconscious phenomena are too simple, too isolated, to give birth to that complex emotional state of the whole individual which is a pain or a feeling of fatigue. This trouble of motion is, then, like the preceding ones, connected with the general theory of stigmata; it manifests, not their negative side, the loss of sensation for the personal consciousness, but their positive side, namely, the permanency in the mind of all sensations, all images under the form of isolated and subconscious phenomena.

§ 4—DIATHESIS OF CONTRACTURE

If M. Lasègue taught us some important characteristics of anæsthetic members, Professor Charcot, since 1878,[1] and his pupils have described a new stigma of movement, which it is necessary to bring alongside the previous one. M. Brodie, in 1837, and M. Duchenne had already been struck with the frequency of contractures in hysteria. Professor Charcot, MM. Brissaud and Ch. Richet, 1880, then M. Paul Richer, 1883, have shown that the frequency of these accidents had its *raison d'être* in a permanent state of the members. An hysterical who has actually no accidents, and whose movements are altogether free, is nevertheless continually in a state of "readiness for contracture"; she has "latent contractures," as M. Brissaud said. The slightest excitation is enough to bring forth in a member that state "of motor powerlessness accompanied by a state of persistent and involuntary rigidity of the muscle, without notable modi-

[1] Charcot, *Mal. syst. nerv.*, iii., p. 416.

fications of the electric reactions and without alteration of the texture of the muscular fibre." [1] It is this permanent disposition which Professor Charcot distinguished by the name of diathesis of contracture.

We are very far from maintaining, as we have often said, that all hysterical phenomena are purely psychological, and particularly, that there is nothing organic in the state of contracture. It is very possible—we do not even dispute the question—that there is with some hystericals a diathesis of contracture, depending on an alteration of the muscles or the cord. We only say, with M. Paul Richer,[2] that there are many contractures of psychical origin, and that in the present work we are treating only these. Leaving aside, for the present, accidental contractures, we wish simply to show that there are psychological phenomena in the very diathesis of contracture, at least as it presents itself in a great number of patients, and we think that for this purpose it will suffice to describe it, showing how near it comes to the preceding facts.

This phenomenon has been very clearly and very properly brought close to the facts already known of paresis and amyosthenia. No one, nowadays, falls any more into the common error which consists in opposing paralysis and contracture as two contradictory terms. We know that these two phenomena alternate with each other, mingle continuously, present themselves in the same conditions, and are very close to each other in their mechanism. MM. Charcot and Paul Richer, in their note to the Society of Biology, say: " The relations of the diathesis of contracture with amyosthenia are the same as with anæsthesia; besides, it is known that these last symptoms usually go together. It is, therefore, not rare to meet with diathesis of contracture in members considerably

[1] Paul Richer, *Paralysies et contractures hystériques*, 1892, p. 2.

[2] *Ibid.*, *op. cit.*, p. 101.

weakened, the enfeeblement of which borders on paralysis." [1] We shall add that it is the same with the phenomena of abulia. Marcelle's hesitations were accompanied by a very marked tendency to contracture which often arrested her arms, leaving them in the strangest positions. It is also the same in all troubles of Lasègue's syndrome, which almost always accompany the diathesis of contracture. These facts are not without interest, for amyosthenia and Lasègue's syndrome depend on absence of attention and personal consciousness. One may thus well understand that absence of attention brings with it absence of self-control and favours the development of contractures. But we think there is a new test of analogous conditions to be made which has not been sufficiently pointed out, and which is more instructive. We should examine the relations which incontestably exist between the diathesis of contracture and the tendency to partial catalepsies, which have been the subject of the preceding studies.

Contracture develops under the same conditions as partial catalepsy. It appears in consequence of an absolutely complete tactile and muscular anæsthesia. With Maria, for example, this tendency to contracture exists clearly on the left anæsthetic side and not on the sensitive right side. Witm., who may be considered as a type of this diathesis, is wholly anæsthetic. She can, as we have already said, enter into a particular state, which should be called complete somnambulism, and in which she recovers all her sensibilities. At that time the partial catalepsies disappear, but, at the same time, we find no longer any trace of the diathesis of contracture. You can, when in this state, raise her arm up without its staying there an instant; you can also touch her skin slightly or strongly, press her muscles, and no contracture follows; and this contrasts astonishingly with her

[1] From Gilles de la Tourette, *op. cit.*, p. 445.

state of anæsthesia, during which the least excitation brings about a contracture. Better still, this patient has often contractures when awake, provoked either artificially or naturally, by an attack or a shock. It is not much trouble to undo them; it is enough to put the subject to sleep, and make her pass into a state of complete sensibility. She will at once move her limbs herself and spontaneously undo her contractures, without anyone's touching her. It is so with Maria, Lucy, and many others. The diathesis of contracture, like partial catalepsy, accompanies anæsthesia and disappears with it.

We know quite well that there are some exceptions, and that contractures may be induced on even the sensitive side. This occurs rarely. It presents itself only with subjects who, either from their anterior accidents, or in consequence of experiments, are accustomed to contracture, and it then connects itself with another category of phenomena; contractures produced through an idea, through suggestion. The diathesis of suggestibility is not always identical with that of contracture.

When there is anæsthesia, the circumstances which provoke contractures seem very different from each other. The thorough massage, the shock of the tendons, the pull of the members, their sudden flexion, the rub of the nerves, the application of a vibrating tuning-fork, the faradisation, the application of a magnet, the breathing on the skin, Esmarch's bandage, etc., similarly provoke this phenomenon.[1] We say nothing of suggestion, because it seems to us a somewhat different fact. All the other provocations of contracture are different only in appearance; they are cutaneous or muscular excitations which induce sensations. Some authors are puzzled in this study by the remark that the sensation is not perceived by the subject.[2] This no longer embarrasses us,

[1] Paul Richer, *op. cit.*, p. 55.

[2] Pitres, *op. cit.*, i., p. 111; Paul Richer, *op. cit.*, p. 62.

for we know quite well that such sensations exist, although the subject himself cannot account for them. It is exactly the same phenomenon that is observed in partial catalepsies. The postures of the arm are unquestionably provoked thus by certain tactile and muscular sensations, which, again, the subject does not seem to perceive.

Contracture is now developed. We must notice a detail on which we have often had occasion to insist.[1] Contractures may be systematic, and give to the member exactly the attitude of a cataleptic member. During the course of an experiment upon unconscious acts, we had suggested to Léonie to take, on awaking, a flower from a bouquet. She did it unconsciously; but, in an instant, looking at her hands, she uttered a cry. The left hand (the anæsthetic hand) was wholly contractured into a graceful but troublesome position: thumb and index finger brought together and holding a rose, and the other fingers slightly curved, but equally rigid. N., in consequence of experiments on partial catalepsy, had her hands contractured in the position of prayer, etc. The authors who describe catalepsy itself cite patients who remain immovable in a systematic attitude, but who are contractured: "the body, stiffened in an attitude of prayer, the knees bent, and the hands folded, could be thrown over without changing its position."[2] Justine had naturally, in various circumstances, her hands contractured in the position of a pianist reaching an octave, her left hand in the position of holding a parasol, etc. We shall see many like examples in speaking of accidents. It is just to remark that, with the exception of a few cases, these systematic contractures do not continue a long time under that form. Contractures, as, indeed, all subconscious phenomena, have a tendency to

[1] *Autom. psych.*, pp. 356, 358.

[2] Saint-Bourdin, *op. cit.*, 1841, p. 53.

generalisation; they are invading in character. Gradually, contracture reaches all the muscles of the arm, and the member then changes its attitude. It takes a special position which we shall study farther on, one always the same, determined by the unequal power of the different antagonistic muscles.[1] This does not prevent that at the outset, and sometimes for a considerably long time, the contracture may not have been systematic as a cataleptic attitude.

It would seem, however, that there is a great difference between partial catalepsies and contractures. Generally, and it is the rule we have given in respect to catalepsies, it is sufficient for the subject to have some sort of information concerning the position of his arm, simply by the sense of sight, to undo the attitude given to him and immediately to recover the free use of his arm. In contractures, on the contrary, the subject looks at his arm in vain; he cannot move it, nor modify its position. We think that a large number of intermediaries may establish a *rapprochement* between these two extremes. With Rose, the position of the left arm, while remaining purely cataleptic, since we can modify it as we wish without experiencing any resistance, loses one of its characteristics. The patient looks at her arm in vain; she cannot lower it; she cannot recover her power over it. With others, matters go farther. The arm raised up without their knowing it, is at first cataleptic; but after a certain time—a quarter of an hour for Lucy, a few minutes for Justine—it stiffens more and more. Not only can the patient no longer move it by looking at it, but we can no longer stir it by touching it. Partial catalepsy has gradually been transformed into contracture. With S. even partial catalepsy determines a contracture, which gradually gains upon the patient and invades the whole body.

It is not always necessary, in order to see the analogies

[1] Paul Richer, *op. cit.*, p. 156.

between the two phenomena, that this transformation should take place. We know that one of the conditions of partial catalepsy is electivity. When this fails, the cataleptic state may take the appearance of that of contracture. If another than ourselves were to try to displace Léonie's left arm, which we raised, he would meet with astonishing resistance. He would find that the arm is stiff up to the shoulder, and would give exactly the diagnostis of hysterical contracture. It is true that we have but to touch her arm to move her in any direction. This arm is contractured for you and cataleptic for us.

Lastly, when electivity is of a high character, when a patient has been very often hypnotised and dominated by an operator, her contractures, even the natural ones, those which came upon her, for example, in consequence of attacks, are transformed for this operator into simple catalepsies. Léonie, Lucy, even Margaret, come to us to show us their contractured arms that we might set them right. All that is necessary for that is, while the patient's head is averted, for us to displace gently the arm and fingers as if they were cataleptic. Massage itself even, which is so happily employed for other patients, seems to have an identical effect, and to provoke more roughly new muscular images which modify the too persistent images.

These observations, which we cannot here discuss in detail, seem to us sufficient to bring closer together the two phenomena and give them a general explanation of the same kind. M. Pitres[1] has already observed quite correctly that this contracture is not a purely muscular phenomenon, since it sufficed to rub the skin over the tibia to establish it. We shall go but a little farther in the same direction. It is not, at least in the majority of cases, a purely elementary reflex, since the contracture produces systematised attitudes with co-ordination of the

[1] Pitres, *op. cit.*, i., p. 385.

various muscular contractions; since it alternates with catalepsies, which are themselves superior phenomena; since it obeys the touches of a determinate person, and manifests electivity. There must be here, also, a certain psychological mechanism. If we leave aside a few contractures, purely organic, the existence of which we have neither affirmed nor denied, we may say in a general way that contractures of psychic origin, the only ones we have studied, are phenomena analogous to partial catalepsies. They are also due to subconscious phenomena, which should be connected with sensations and kinæsthetic images existing by themselves, namely, alone and outside the personal consciousness of the subject. On either side, exterior excitations provoke such sensations.[1] The latter, by reason of the retraction of consciousness, of absent-mindedness, and anæsthesia, are neither controlled nor arrested by other psychological phenomena, and tend to persist indefinitely, manifesting themselves as they always do by outward movements. One thing alone might embarrass us, and that is, that subconscious acts, as has often been seen, are feeble acts, performed with continuity but without energy, for they are not connected with those emotions, those efforts of attention, which induce vigorous acts. But we should not yield to illusions. Contractures, notwithstanding their appearance, are also feeble acts. Many authors, and recently M. Paul Richer, have set it forth in many observations.[2] Formerly we tried to account for it in a more elementary manner. We had slipped a dynamometer into Rose's left hand, at the moment when the hand was being contractured in flexion with apparently very great force. The instrument was caught and held fast in the contracture, but it indicated only 9; with another patient

[1] Féré, *Sensation et mouvement*, 1887, p. 23.

[2] Brissaud et Regnard, *Soc. de biologie*, 1876; Pitres, *op. cit.*, p. 383; Paul Richer, *op. cit.*, p. 121.

we got 12, but never more. Now, these numbers are exactly those which are very easily obtained by subconscious acts. They do not seem to indicate that any greater strength was necessary in contractures.

Another difficulty may be raised in regard to the duration of these contractures. We shall later have a few remarks to make on this point and shall show that this duration and permanency are often illusory, especially when the question turns on accidental contractures produced on sensitive members. In all accidents considered as contractures in clinics, the muscles are far from preserving an absolutely immutable contraction. We must, however, observe that, if the member is truly anæsthetic, the contracture is but little variable and does not present in its curve, registered by apparatus, those starts and oscillations which are generally due to fatigue.[1] Even in this case, the contracture does not resist indefinitely; if you exercise upon a contractured member a continued traction, you will see that the member gradually relaxes. This permanency of a feeble contracture is, therefore, wholly relative. It has nothing more extraordinary than the catalepsy of an arm remaining suspended for an hour. Here, again, it is the absence of the phenomena of pain, fatigue, and emotion, which permits the contracture to become prolonged until the physical strength of the organs is exhausted. This exhaustion, despite the absence of the feeling of fatigue, is so real that every contracture, like every prolonged catalepsy, is followed by a paretic state of the member.

After having established the analogies, we must not, however, misunderstand the differences. Catalepsy and contracture are two different forms of subconscious acts. In contracture, it seems that the motor images are still less conscious, still more separated from the personal perception of the subject, who is entirely unable to recover

[1] Charcot, *Mal. du syst. nerv.*, iii., p. 121.

his hold on them. These isolated images are less disposed to become systematised, and form groups around a preponderating image. They manifest less electivity and recognise less readily the ordinary master; they obey only rougher processes—massage, for instance, and continued traction. In a word, they are less intelligent. As will be seen later, cataleptic obedience depends on a certain intelligent grouping of subconscious images, on a rudiment of second personality. In contracture, this grouping takes place more rarely or not at all. It is another form—one more advanced—of psychological disaggregation.

We do not hesitate to confess that these last considerations are very hypothetical. Outside of cases of suggestion and evident training, it is very difficult to say why the subconscious act manifests itself now under one form, now under another. A single general notion remains evident, namely, that these alterations of movement are, like the foregoing, consequences of subconscious phenomena and consequently connected, like all the other troubles of movement, with the mental stigmata of hysteria.

CHAPTER V

THE MODIFICATIONS OF CHARACTER

THE study of the character of hystericals had, for many authors, a great importance, for they united under this title all the psychological phenomena exhibited by the patients. These very numerous phenomena have already been, in this book, the object of some distinct studies, and will be still farther analysed in respect to accidents and fixed ideas. The hysterical character becomes, therefore, here a subject of study much more restricted and far less important. We can, under this title, study only the general modifications produced by psychic stigmata in thought and conduct.

Even in order to make this restricted study, some precautions have to be taken. The character depends mainly on the primitive intelligence of the patients, on the surroundings in which they have lived, and on their education. Hysteria may attack very different persons—rich and poor, intelligent people and fools, virtuous and vicious persons. We should not attribute to any malady traits of character which would have been exactly the same independently of the malady. We must, therefore, describe only the modifications of character; the transformations which the malady has evidently brought with it in the conduct of patients. We must also guard against another danger. Hysteria exposes patients to numerous mental accidents, especially to fixed ideas and

to impulsions. These altogether accidental phenomena, extremely variable in different subjects, are not traits of character, and depend less on the malady itself than on certain external circumstances. We shall endeavour to avoid these two dangers in describing the intelligence, the will, and the sensibility of these patients. We think that after the preceding studies we need insist very little on the intelligence and the will, and describe more completely the emotions and some particular facts to which tradition gives a certain importance.

§ 1—MODIFICATIONS OF INTELLIGENCE AND OF ACTIVITY

"After numerous attacks," says M. Briquet, "most hystericals experience changes in their intelligence. They lose their memory; their faculty of concentration diminishes notably; they become incapable of the slightest sustained attention. . . . Some become heavy and manifestly lose their intelligence."[1] Whatever be the illusions which an apparent vivacity and some few brilliant faculties, more or less retained, may cause, we think that M. Briquet's opinion is correct in a general way. Not only after numerous attacks, but gradually after the beginning of the malady is the intelligence of the patients lessened. Of course, this lessening is altogether relative and can be appreciated only by persons who knew the patients well before.

This diminution affects principally a special element of intelligence—the power of advancement in the acquisition of new ideas. It is only gradually and at a later period that hystericals truly retrograde; but, from the beginning of the disease, they cease to develop. Instruction is entirely arrested, whatever be the age of the subject. Louise, up to that time, had been an excellent pupil in her school, but at the age of eleven she ceased to understand anything, to learn anything; for three years now

[1] Briquet, *op. cit.*, p. 384.

she has passed through the different stages of her malady, but has not recovered the faculty of learning. If she be not cured, her progress in learning will be definitively stopped at the age of eleven. And so with all other hysterical, only at different ages; and this arrest of the mind at a certain period largely determines the special aspect of different patients, the production in them of that generally infantile mind which we observe in all their conduct.

This incapacity for new instruction is bound up with phenomena which have been studied a long time, for example, with the difficulty or the impossibility of attention. It is useless to return to their way of listening or reading, to their difficulty in understanding a new idea, to their perpetual and really specific absent-mindedness. It really all depends on their continuous amnesias, which exist to a certain degree with them all; it depends on the hesitation with which they perceive and apprehend new events, on their doubts, their astonishments; in a word, on all the enfeeblements of the intellectual synthesis.

In hysteria, by a sort of perpetual contrast, all the phenomena of intellectual automatism are, on the contrary, exaggerated. Every time that, by chance, they succeed in understanding a new idea, or remembering an old one, that idea takes on an immense development. We described, formerly, while studying the character of suggestible individuals,[1] the singular manner in which Lucy related a story. She was not long in seeing the picture of the events unfolding before her on the wall. Instead of relating, she described what she saw, as children do at the theatre, in a series of naïve, simple exclamations. Renée observes on the skin of her cheek little black spots. She is told that they are small worms. Since that she has for a whole month a horrible spectacle be-

[1] *Autom. psych.*, p. 206. I described in this chapter all these phenomena, with many more details and other examples.

fore her eyes. She sees a part of her cheek bleeding and devoured by maggots. Bertha cannot think of anyone unless she can see and hear him speak. If she happens to understand well what is told her, she shows such a credulity as necessitates great caution in whatever may be said. Some one watching her slowly eating her breakfast, said, laughing, "Did you poison your soup?" and she is at once possessed with the idea that she has poisoned her soup and that of her companions. These facts will be studied with more details in regard to suggestion.[1] It suffices simply to point them out here.

But there is a manifestation of intellectual automatism practically more important than all the others, namely, the tendency to ceaseless reverie. Hystericals are not content to dream constantly at night; they dream all day long. Whether they walk, or work, or sew, their minds are never wholly occupied with what they are doing. They carry on in their heads an interminable story which unrolls before them or is inwardly conceived. You think Justine is listening to you while you talk to her? No, for all at once you hear her murmur low: "No, sir, you are a savage." When you shake her, she will excuse herself and tell you that she was thinking of a horrible policeman who was going to carry off a little dog to the pound. Bertha makes us constantly repeat to her what we have said, and adds: "It is not my fault; I was no longer listening; I fancied I was disinterring my mother and hovered with her in the clouds." Her eyes seem to read a book, but her face tells another story: "When I shall die, I shall have a small white bouquet on my small tomb, . . . flowers speak, they are very gentle persons; I shall talk to them, for they are not bad. . . ."

[1] *Cf.* "La suggestion chez les hystériques, conférence faite à la Salpêtrière," *Archives de neurol.*, novembre, 1892. La suggestion sera étudiée dans le second volume de cet outrage, ayant pour sujet "Les accidents mentaux de l'hystérie."

And here we can see her tears flow over a book which is very entertaining and gives not the least occasion for her grief. It is certain that it is not easy to understand what such an one reads when such stories are told.

These reveries sometimes have no development; they are variable, incoherent images, which pass before us like the colours of a kaleidoscope, though they have often a certain vague unity about them. It is always the same monotonous story which the patient resumes at the point where she has been interrupted, or unceasingly begins over again. Be that story cheerful or painful, it does not matter; it becomes pleasant to these weary minds, because it is an easy reverie: "How unhappy I am! . . The idea is frightful, but it lulls me, and I am ready to defend it against any one who should want to take it from me; let me think of my little tomb; it gives me so much pleasure. . . ." When reveries get to be systematised in this way, they become more dangerous and are soon transformed into fixed ideas. The predisposition to fixed ideas, of which we see here the germ, is one of the great features of the hysterical mind.

We should also describe here the parallel modifications which activity presents, if we had not insisted, at such great length, on the hystericals' abulia. The lack of will gives hystericals a general aspect which alone enters into our present study. They become indifferent to everything and allow themselves to be led as children. A husband declared that his wife was becoming too docile and that this was not normal. They stop working spontaneously, but sometimes, when constantly directed, they will do something or other. They are like those backward creatures of whom M. Bourneville says, "They are incapable of working with any kind of judgment when left to themselves, but may still be utilised when subjected to some discipline."[1] This obedience among hys-

[1] Bourneville, "Les enfants arriérés," *Archives de neurol.*, 1892, ii., p. 149.

tericals gives but few results, for they do nothing seriously; they have no longer any perseverance [1] and abandon an undertaking before any new and trifling difficulty. They no longer know how to adapt the present to the future, and, in their lack of forethought, they, so to speak, confine human existence to the present moment.

Not to return to known facts, we shall point out here only one of the great consequences of abulia, namely *ennui*. "Ennui is a plague which we try to avoid in society and which more than one unfortunate meets everywhere, even in the midst of the gay world. It is complete emptiness, the extinction of all activity and of all vigour; a depression, a laziness, a lassitude, a benumbing, a disgust, and, what is worse, a mortal blow given to the intelligence and to all agreeable sensations." [2] Ennui finds us because we have no longer either the power or the will to feel; "because our head is empty enough to seek everywhere amusements; because our mind is too dull to seek them anywhere." [3] Is not this a perfect description of hystericals? We shall not be surprised to find among them the true ennui; that which no amusement can dissipate, and which is a malady of the mind composed of desire and impotency.

Along with abulia, there is always the apparently opposite phenomenon, the exaggeration of automatic activity, the indefinite duration of a work once begun.

He took it into his head—relates J. J. Rousseau in his *Confessions* [4]—to teach me chess, which he played a little, and, after having learned somehow or other the moves of the game, my progress was so rapid that before the end of the first game I gave him the tower he had given me when we began. I needed nothing more to fall madly in love with the game. I

[1] M. Huchard, "Mœurs des hystériques," *Archives de neurol.*, 1882, i., p. 199.
[2] Zimmerman, *De la solitude*, 1840, p. 19.
[3] *Ibid.*, *op. cit.*, p. 23.
[4] J. J. Rousseau, *Confessions*, i., p. 395.

bought a chess-board; I bought the chessmen; I shut myself up in my room; I spent days and nights in studying chess.

Who has not seen patients get an idea into their heads, as we say, and read, without stopping, a novel in several volumes without skipping a line and without understanding a word? Others work intently day and night at a piece of sewing, after having remained idle for weeks, etc.[1] Here also we find the germ of those fixed ideas and of those impulsions which we shall have to study as one of the principal accidents of hysteria.

§ 2—THE EMOTIONS

The lacunæ of normal psychology have naturally such consequences as increase the difficulties of pathological psychology. Emotion is one of the least known of moral phenomena, and its modifications are very difficult to determine. One of the clearest notions that have been acquired recently on this point is elucidated in the works of M. William James.[2] Emotion is not a simple phenomenon, a manifestation of the faculty of sensibility, as was once thought; it is an ensemble of a great number of elementary phenomena, a state of complex consciousness. "The more we think of it," said M. Guyau, "the more we fear the complexity of what is called a state of consciousness and of the indeterminable number of simultaneous sensations it involves."[3] To be moved, and especially to be moved in a certain way, there must be in one's consciousness the sensations of all kinds of momentary changes which take place in all the organs. The respiratory apparatus, the heart, the skin, the viscera, the blad-

[1] See, for examples, *Autom. psych.*, p. 209.

[2] William James, "What is an emotion?" from *Mind*, 1884, and *The Principles of Psychology*, 1890, ii., p. 442.

[3] Guyau, *La genèse de l'idée de temps*, 1890, p. 18.

der itself, "this mirror of the soul," according to the expression of a surgeon, are modified in a special manner in every emotion. To experience this emotion, is to experience all these modifications. Add to these sensations the images of the remembrance which recalls them into life,—the movements of all kinds which are begun, produced, or arrested,—and you will have the notion of the complexity of an emotional state.

If this is so, we can apply to the emotions the remarks so often made concerning psychological syntheses. We must, for emotions as for sensations, for remembrances and acts, distinguish the actual and new syntheses, in which is to be consciously produced a new combination of sensations and very complex images, which have not yet been presented in this way, from the more or less automatic repetitions of former syntheses. There are emotions incessantly new, of course, differing from each other in certain shades, which we can so perceive as to be able to connect them with our personality in regard to each new situation, and all old emotions, which are repeated to-day without any relation to the present situation. These notions are not purely theoretic; they correspond with facts which can be observed in the patients.

Without seeking paradoxes, we think we may say that hystericals have in reality fewer emotions than is generally thought and that their principal character is here, as it is always, a diminution of psychological phenomena. These patients are in general very indifferent, at least to all that is not directly connected with a small number of fixed ideas.

With Renée, we have gradually seen disappearing the taste for finery; her coquetry — vanity, even — disappeared. With others, the love of property is gone; they lose all that belongs to them and do not care. Bertha formerly had great timidity; she now wonders at the loss

of it. She goes and comes at night; she looks at dead bones of which she was afraid in past years, and asks: "Why does all this make no impression on me now?" Maria, especially, is very curious as to that. She takes no longer any interest in things or people. Overwhelmed with misfortunes, consequences of her malady, and, after having been in comfortable circumstances, reduced to extreme poverty, she does not perceive that her situation is serious. She loses money, when she has only a few pennies left; she mislays her clothing, can scarcely keep on the dress she is wearing, and does not seem to trouble herself about it in the least. Yet we observe that she is still intelligent and might provide against her situation. She does so very little, and only wonders at her indifference. "Formerly I took care of my things; now I do not." There are some still more characteristic facts to be observed in this patient. Formerly she loved her husband, and was even quite jealous about him. She was devoted to her two children. Since her illness she has gradually abandoned her children, who have been reared by her sisters, and she finally left her husband. For the last three years, instead of her former happy life, she leads about Paris the most miserable existence. Not once did she inquire about her husband or her children. She heard indirectly of the former's death. "Strange!" she said, "it does not affect me in the least; yet, I assure you, it does not make me happy, either. . . . I simply don't care." "But if we were to tell you that your little Louis [it was her favourite child] is dead, too?" "How do you suppose it can affect me? I have forgotten him!" Another observation will give still more precision to the character of this state. At times, as it often happens with hystericals, Maria comes for a short while out of her psychological feebleness. Thanks to rest, to good food, to a succession of good nights, she loses her stigmata, recovers her tactile and muscular sensibility,

her remembrances, etc. We behold then a singular spectacle. The poor woman is now in despair; she calls for her husband, her children, her house. There is no one to tell her about them. Then she cries, refuses to eat, speaks of suicide. She might be thought much worse than she is, now that she is getting well. We have often observed this fact in our treatment of the insane. The first ray of reason, the struggle with their dreams, upsets them and brings about disturbances apparently much more serious than their former quiet malady. Maria is thus in despair about her abandonment of her children. She is ashamed of all her faults, frightened at her misery, until the hysterical state returns with its insensibility and its indifference. There is here a veritable psycholgical apathy, a psychopathia, if we may so say, which should be connected with the stigmata it accompanies. In regard to Maria's indifference to her husband and children, we would incidentally refer to a small matter that has often struck us (and we do so without attaching any special importance to it); it is simply a curious observation. It was necessary to make with Maria a vaginal examination on account of a metritis, and this examination allowed us to observe two psychological characteristics which are striking during the periods of great psychopathia: (1) Maria has no shame whatsoever, although she received a refined education; she is not obscene, she is only profoundly indifferent; (2) she is wholly anæsthetic in the genital parts, and has probably been so for a very long time; she has not the least notion of what is called the genital sense. We have overheard strange conversations on this point. Other women maintained before Maria that pleasure was necessary for fecundation. "Why!" said Maria, "I have had children, and I do not know yet why people maintain that there is pleasure in it."

Let us now examine the same facts in the other period

which we have pointed out. Ascertaining that sensibility belonged to the whole body, we wished to verify if there were such a modification in the genital parts. This verification presented an unforeseen difficulty, for the modesty of that patient had become very delicate. Genital sensibility, as we expected, was complete and, at that same moment, Maria was mourning her husband and children. This observation may be interpreted as one may wish; we insist on only one thing: Family feelings, affectionate emotions, modesty, and genital sensibility disappear and reappear simultaneously with this woman. Which of these phenomena brings the others along with it? Is genital sensibility a centre around which the other psychological syntheses are gathered? We do not wish to draw any conclusion. It would be necessary to meet with many facts of the same kind and analyse them better than we have been able to do before undertaking a study of these emotions. This is certainly a very extraordinary case, and it is for this reason that we selected it; but if we examine the other patients from this standpoint, we shall see oftener than we think similar facts. Hystericals, above all, lose quickly social sentiments, altruistic emotions, perhaps because they are the most complex of all. Bertha, who for some time retained some affection for her brother, at last lost all interest in him. She herself complains of not being any longer able to love anyone seriously. Marcelle, at the outset of her disease, avoided everybody. It was very soon seen that Isabella wished to be alone. All, in fact, very soon fall into a state of unsociability, of misanthropy, which they try in vain to disguise. They wish, they say, to think all alone; and, in fact, their tendency toward revery has something to do with this partiality for isolation. But, really, they do not like society; they lose gradually their friendships and their affections. During their illness, they are generally incapable of acquiring

serious sentiments of gratitude and sympathy. With the exception of the somnambulic passion, which is an altogether special phenomenon, they forget people in a short while; in fact, they have never loved them.

Evidently there are here, as always, variations and degrees according to the gravity of the malady. Marcelle, at the outset, retained her former affections, but was unable to make new acquaintances. Others, again, will find it hard to understand only the persons about them, to understand their feelings, to sympathise with them. "How strange!" Bertha keeps repeating; "how the world has changed! In past years I used to meet kind and affectionate persons; now I no longer see any." She does not know that she is paraphrasing one of Rousseau's sayings: "Why is it that, after having found so many good people in my youth, I should find so few in my ripe age? Has their race degenerated?"[1]

This general disposition, more or less developed, explains a well-known characteristic, namely, the selfishness of hystericals. M. Despine has already remarked on it in his observation of Estelle. "This young girl," he says, "is busy only with herself. She cares for others only so far as she is concerned, or, again, does so out of civility, but always with repugnance and fatigue, because the *I* is the spring of all her actions."[2] "Their personality is ever foremost," said, later, M. Huchard; "their *I* is ever uppermost. This is because they are often selfish, think but of themselves, of their miseries, great or small."[3] This selfishness manifests itself in various ways; it is that which is added to their want of moral support, a want they all feel, which is the basis of their vanity, their wish to be noticed, listened to, and led by others.

[1] J. J. Rousseau, *Confessions*, i., p. 267.

[2] Despine (d'Aix), *op. cit.*, p. 40.

[3] M. Huchard, "Mœurs des hyst.," *Archives de neurol.*, 1882, i., p. 202.

It is indeed curious to see their feeble personality, their very incomplete *I*, play so great a part and absorb all the strength of their intelligence. Yet it is easily explained. To love others, that is, understand others, is, in reality, an affluent mental activity. We must, in order to reach it, add to the synthesis of our own psychological phenomena those of others and construct in our thought a larger synthesis than that of our own personality. These poor creatures cannot understand themselves. They have not strength enough completely to build up their own personality; therefore it is quite natural that they cannot assimilate that of others. Selfishness, in hystericals, is a result of mental weakness, of the diminution of all sympathetic emotions.

We are already accustomed to the contrasts which the mental state of hystericals presents, so we shall not be very much surprised to learn that these apathetic, unemotional patients are, at the same time and from another point of view, extremely excitable and susceptible of very exaggerated emotions. With some of these patients, susceptibility is truly enormous; any kind of accident, a word, a look, provokes an altogether disproportionate scene. Witm. and Margaret are angry for whole weeks, because, they say, people have looked askance at them. Celestine gets into frightful spells of anger. Louise starts with terror and cries as soon as she hears someone enter. Bertha has fits of inconsolable despair, etc.

These emotions, whose existence must be recognised, have, we think, very clear characteristics which distinguish them from normal emotions.

1. They are greatly exaggerated in their manifestations. The facility with which they can be modified by amusement, the slight trace they generally leave in the mind, shows that there is very often but little real feeling connected with these loud cries and this great despair.[1]

[1] *Autom. psych.*, p. 214.

2. When the emotion is real, it is not in sufficient *rapport* with the circumstances that provoked it. It is disproportionate—without shading, without justice. Instead of changing incessantly, according to the thousand incidents of life, it has a mechanical regularity and remains always the same. When we are irritated by someone, we can be so in a hundred different ways. One day it is a gesture, another, such or such a word, a third day, blows. When Celestine gets angry, it is not a very complicated matter; it is always and everywhere the same anger. To blush, to cry out loud, to abuse people, and that abuse always the same, strike whom she can with her fists, break a few window-panes, constitutes usually the whole programme. Sometimes this lack of adaptation to circumstances on the side of emotion is still clearer, and the patients have contradictory feelings, the reverse of those they should experience in reality. Renée begins to cry when she should be happy; she feels the need of saying disagreeable things to the persons she most loves, and falls a-caressing those she detests. It would seem that there is a mechanism that regulates all this development of emotions and that this mechanism is put out of order, as in the phenomena of allochiria or heterokinesia.

3. Different emotions are not numerous with the same patient. It would seem that each patient has her own emotion and always the same. Louise is a coward: all impressions, whatever they be, bring with them fear. Celestine is passionate: every excitement, a surprise, bad news, as well as a reprimand, provokes a fit of anger. If you try to arouse Bertha's emotions, be it by pain, surprise, jest, etc., she will always react in the same way, namely, by a kind of despair which is her special emotional state. She grows pale, cries, suffocates, whines: "How unfortunate I am! What an inferior being I must be! Why should I live on? I am cursed." And

it will be thus always. One would say she is reciting a lesson.

And, in fact, she does recite. Her emotion is not a real emotion; it is not a synthesis of phenomena created by her mind at the moment when we speak to her, and *en rapport* with the words we pronounce. It is a former emotion which grew in consequence of her family troubles and her all-too-real grievances. This emotion became systematised, and it is quite ready now to work one way or the other. There are, in a word, automatic emotions like automatic acts, and the former, as is always the case, are maintained with hystericals, and exaggerated. It is right to add that this exaggeration of the former emotion depends on the general character of hystericals, to the retraction of their field of consciousness, which obliges them ever to adhere to isolated thoughts, without antagonistic ideas, without counteraction. "A given impression," rightly observed M. Laurent, "effacing suddenly the ideas of the past, the hysterical finds himself in the situation of a man who learns everything at once or sees some unexpected thing. This impression expels the other ideas, and, overruling the intelligence, causes, according to its nature, astonishment, fear, joy, without being counterbalanced by anything."[1] We shall see, in studying suggestion, this power which an automatic phenomenon acquires, thanks to the present weakness of the personal perception.

After having observed this general character of emotions existing in these patients, we must see under what particular forms they oftenest present themselves, what are the most frequent kinds of emotions. Nearly all simple emotions—joy, gaiety, surprise, fear, etc.—can develop, especially in those who are not too ill to understand any longer new situations; and each of these

[1] L. Laurent, "De l'état mental des hystériques," *Archives cliniques de Bordeaux*, Sept., 1892, p. 4.

emotions will wholly invade the mind with the same exaggeration and regularity. But we must recognise that the sad, depressing emotions are by far the most frequent. There has often been pointed out a quite correct distinction between the hysteria of man and that of woman. The hysterical woman is represented as full of agitation—restless, gay, laughing loud, doing a thousand strange things; and the man, on the contrary, as more sad, more melancholy, and inert. Things present themselves more commonly in this way, and it is certain that the hysteria of a man, "this upsetting," as M. Briquet[1] says, "of the constituted laws of society, is more painful, more cruel than that of a woman. A man suffers more from this inertia, from this destruction of all vitality, and his moral weakening is more astonishing."

But, behind this apparent difference, there is, at bottom, a resemblance, and hysteria is always essentially the same. Melancholy and sadness are the dominant feelings with women as well as with men. All the patients of whom we have spoken are sad, despairing; continual weariness, disgust of life, fear, terrors, extreme despair, are what they continually express. Bursts of wild cheerfulness are merely accidents in the midst of a very monotonous sadness. They confirm a thought often expressed by philosophers, and recently taken up again by M. Féré: "The sensation of pleasure is derived from a sensation of power, and the sensation of displeasure from a feeling of impotency."[2] We shall go even farther, and, despite hysterical vanity, which sometimes exists, but of which too much has been made, we will say that they are often very humble, incapable of daring anything, discouraged by trifles, and diffident. Those among them who are not conscious of their condition are the rarest; most have discovered before us that

[1] Briquet, *op. cit.*, p. 101.

[2] Féré, *Sensation et mouvement*, p. 64.

they have lost all will and sentiment, and they are disgusted with their miserable existence. "I am crazy; it fills me with shame," says one. "I am stupid; it is not worth while to be known as such," says another. And ever the same burden: "I was not so formerly." These characteristics are perhaps less picturesque, but they are truer than are the usual representations.

Another group of emotions springs from their selfishness. Very much preoccupied with their feeble selves, they claim all kinds of care and attentions; they ask of others the moral force they have not within themselves, and, finding themselves always helpless, they think themselves always neglected. They are troubled when they represent to themselves the strength, the happiness of others, and are extremely jealous, very irritable, and prone to anger. Jealousy, that great passion of small minds, is the continual torment of the hystericals; it is an almost necessary complement of the somnambulic passion which we have already treated. There is sometimes with them real suffering at the thought of other people's pleasures. We only mention all these moral perturbations, which are very curious and probably quite regular, like all phenomena of hysteria. Their study will later form the starting-point of ethics; at present, psychology is not yet capable of analysing them.

§ 3—A FEW PARTICULAR DISPOSITIONS

We have described only a few general and simple traits of character, which, by their combinations and under the influence of determinate circumstances, may produce all sorts of attitudes and particular acts. It is impossible to enter into this description, which would come nearer a romance of morals and manners than a medical clinique; but hystericals, having attracted attention these many years, have a reputation and a legend; and a certain

special conduct, as wholly characteristic, is attached to them. We shall say what we consider to be just in respect to them, and shall do it in a few words.

After having accused hystericals of all the crimes of witchcraft, and having reproached them with cohabiting every Saturday with the devil, disguised as a he-goat, people have long preserved a vague remembrance of these superstitions, and have maintained that these patients had an eminently erotic disposition. This belief was connected with the uterine theory, so well disposed of by M. Briquet. At the present time, this quarrel being ended, we can examine matters more coolly. This erotic disposition exists, we think, in hysteria just as all possible fixed ideas do. We have collected, out of a hundred and twenty observations, four where it plays a rôle altogether predominant. There is nothing very strange in this. Amorous passions, sexual desires, must exist with these persons, most of them young, as they do with others. Hystericals hear people talk of love, see the evidence of it, read descriptions of it;—why should their mind, so ready to receive impressions, so docile to all influences, resist this one? In the hysterical delirium, especially, of which we shall speak later on, the patients speak very often of lover, husband, rape, pregnancy, etc. Now, you cannot put into your delirium what is not in your mind. These things greatly preoccupy people of that age and sometimes of another age. It is quite natural they should manifest them in their dreams. Have we any proofs that an equal number of young women, having other deliriums of whatever origin, would not speak exactly in the same way?

The coquetry of these patients has also been made a vast deal of. "They like to have flowers at their bedside; they like red ribbons, blue ribbons, in their hair," etc.[1] We are not disposed to give much importance to

[1] Huchard, *op. cit.*, p. 190.

this symptom. Our experience with hystericals is that they are more often negligent than coquettish in this respect, and carefulness in matters of toilet appears to be a rather favourable sign. When coquetry exists, it is rather connected with that vanity, that selfishness, which we have pointed out as characteristic, than with the erotic, properly so called.

In a word, with the exception of a few special cases, easily explained, the hystericals are, in general, not any more erotic than normal persons. Their physical and moral anæsthesia, this concentration of the mind upon itself, does not incline them toward amorous passions. They are more frequently frigid than sensual; they are rather inclined to forget their former affections than increase them. We must not grossly deceive ourselves—take for love this infantile need they have of being led and consoled, and consider the temperament of some of them as a characteristic of their malady.

A more recent question seems to be also susceptible of a similar solution. Many moralists have thought that the psychological character of the hystericals was their tendency to falsehood, to dissimulation, and especially to a perpetual simulation. We have before said what we thought about this pretended axiom,[1] and are glad that M. Gilles de la Tourette has approved of our discussion.[2] We still believe that all possible defects and vices may be met with in hystericals as well as in others, but that, in their ensemble and by the fact of their malady, they lie no more than others. Instead of taking up to-day this little problem, it would seem more interesting to try to explain how this bad reputation got afloat. Eminent observers, like M. Legrand du Saulle,[3] have under-

[1] *Autom. psych.*, p. 216.

[2] Gilles de la Tourette, "Considérations sur les ecchymoses spontanées et sur l'état mental des hystériques," *Nouvelle iconographie*, 1890, p. 49, and *Traité de l'hyst.*, 1891, p. 489.

[3] Legrand du Saulle, *État physique et état mental*, 1883.

stood the mental state of these patients in a way which at the present time appears to us very singular, and we must find out what facts could have given rise to such illusions.

M. Pitres says rightly that this belief in hysterical simulation rests on errors of interpretation. "Generally speaking," he says, "the love of these patients for simulation has been greatly exaggerated, and this because the phenomena that could not be understood were systematically attributed to fraud."[1] This appears all the more likely, as nearly all psychological phenomena of hysteria present, at first sight, a contradictory aspect and are very difficult to analyse. A superficial observation of the stigmata will show simply one thing, namely, that the patient feels at one time and does not feel at another; that at one time she moves, and at another does not move. If the regularity of the conditions which accompany these two facts has not been observed, the investigator will tire of these capricious stigmata and will consider them as simply jests. Amnesia, above all, as Professor Charcot observed,[2] will put into the stories of the patients lacunæ and contradictions which will render them justly suspicious. Has not the same accusation been made against the patients attacked with alcoholic neuritis? They present an amnesia of precisely the same kind.

Finally, with hystericals, most perceptions, be they inward or outward, are very insufficient, the reveries more or less conscious, hallucinations even mingling with normal perception. Can we hope that in the interrogatories put to them they will give minutely the starting-points of all these phenomena? Will they always be able to distinguish a dream from a reality? How many people in a normal state can do it? "I dare not say anything more," said a patient to us; "I know quite well

[1] Pitres, *op. cit.*, ii., p. 55.

[2] Charcot, *Tuesday Lectures*, 1887.

that I no longer see things as they are. Do not believe what I tell you; it is not true, perhaps." The same difficulties present themselves in the examination of all the insane; yet no one will say that the spirit of simulation is characteristic of melancholy or persecution.

We shall add one more remark, namely, that it is the hystericals themselves who have contributed to their bad reputation by accusing themselves very often of falsehood. Renée has, at the present day, at every moment, fixed ideas and tics, the reality of which we establish, and now we see how she will express herself in regard to her former fixed ideas, which have disappeared. "I used to hold myself crooked; I do not know why. My comrades at the boarding-school told me that I had one hip larger than the other and that I was not well. They so persuaded me of this that I went to consult a physician and asked him why it was that I had one hip bigger on one side. The physician said: 'You do not hold yourself straight.' And I,—but this is too bad,—I maintained to him, that it was not so, that I did hold myself straight. I know, however, quite well *now* that I used to hold myself crooked; why did I say the contrary? What would you have? I lied, evidently." No, not evidently at all. She was in a particular state of mind, which she does not understand, and which she explains on the common hypothesis of falsehood, just as an ignorant person might do to-day before a spasm through a fixed idea. M. Paul Richer[1] published a very interesting letter from an hysterical patient, who no doubt presented phenomena of the same kind, and who wishes to explain everything by simulation, though admitting that she has no very clear ideas on the subject. Numerous cases of this kind may be met with among patients who try to explain their somnambulism or their suggestions. The mediums of spiritualism, when they become old and

[1] Paul Richer, *Paralysies et contractures*, p. 112.

are cured of their automatic writing, themselves pretend having simulated.[1] A physician should not always accept the naïve interpretation which the patient gives of her own mental malady, without looking into the matter.

This problem of hysterical simulation is, we think, largely a question of words. What is to be understood by falsehood, by simulation? Do we take the word, as we should, in its precise sense, as indicating a well-planned and voluntary deception? We say that it exists with these patients, as with other persons—that is, as an individual indication of character or as the result of a bad education. We also believe that, in exceptional cases, it may exist as a suggested and very accidental fixed idea; but we do not think that we could regard it as a specific characteristic of the malady. If, on the contrary, we take this word "simulation," as but too often happens, in a sense extremely vague, as a certain modification of the truth, as an indeterminate psychological alteration, we say that, in this case, simulation may be a summary of all hysteria and of even all possible mental maladies. It is clear that all these maladies consist in thinking and feeling what a normal man should neither think nor feel. The name becomes true, if you wish it, because it is meaningless, because it confounds all the phenomena, and is no longer good for anything else than to deceive us. Falsehood, like sin, is a word of the language of the moralist, and should have no place in the language of medicine.

A last problem has, in fine, been frequently raised: What is to be thought of the suicide of hystericals? We can best answer by referring the reader to M. Pitres's lecture on this subject, whose opinions we share. The ideas of suicide are frequent with these patients, and seem a natural ending of their disposition to melancholy and despair. They may also be connected with the abulia of

[1] *Autom. psych.*, p. 344.

hystericals. Death seems so easy a means for lazy people to solve all life's problems. As to the execution of the idea, it is analogous to that of all the other impulsive fixed ideas. If the disaggregation of the mind is grave, if the fixed idea is strong, it is perfectly realised. M. Legrand du Saulle has reported three cases of suicide followed by death among hystericals; M. Pitres reported one; M. Gilles de la Tourette, one. Among the patients we have cited, Maria has been taken from the river half asphyxiated. This idea of suicide is, therefore, in no wise a jest, and we think that a physician should take precautions against such an idea even when it presents itself in the mind of an hysterical.

Very often, happily, impulsive fixed ideas are not realised. Just as Celestine does not break windows whenever she has a mind to, so a patient does not always kill herself because she thinks of suicide. In general, as M. Pitres says, these impulsive acts are ill-prepared, simply because they are neither carefully considered nor voluntary. The least difficulty, the least emotion coming between, permits consciousness to recover itself and changes the course of ideas. The following anecdote, told by Bertha, of whom we have often spoken, will save us commentaries:

I loved him so much, but grandma would not let me! . . . Oh! I should have triumphed over everything, for I felt him always by my side supporting me. . . . It became necessary to end. . . . I left the house at night, without making any noise, with the purpose of drowning myself in the big pond. Oh! how beautiful it all was! The black mountain before me, the moon shining through the fir-trees, and, in the glittering water, white flowers laughing at me. I began to cry, like the fool I was, and returned home without knowing what I had gone out for.

In studying this character, which we have just summed

up, attributing it to hystericals, the reader will probably make the same observation as has often come to our own mind. These traits belong, perhaps, to hystericals, but they belong also to many other patients, and this special characteristic is, on the whole, a rather common one. Inattention, feebleness of thought, revery, abulia, fixed idea, absence of new emotions, and excess of common emotions are things we meet with very often. Patients attacked by the folly of doubt, the obsessed, the impulsive, present to us the same picture. It is true, they are nearly related to the hystericals. Better still, if we read the beautiful descriptions of M. Lombroso of criminals, we shall be surprised to find again the same observations. It would seem that M. Lombroso refers very often to abulic hystericals. The imbeciles whom M. Sollier described recently, when they are not too inferior, have the same weaknesses and the same defects. Finally, there is a last comparison to be dealt with. This defect of synthesis, this instability, this naïve selfishness, accompanied by jealousy and anger, are found exactly in a state which is in no wise sickly, namely, in childhood. Who, examining an hysterical, has not said a hundred times, " Why, she is but a big child"? The hysterical, like a great category of patients, has no longer any greater power of thought than that of the child. But that which is normal in the child, because it does not act alone, having but few thoughts to understand, becomes a malady at twenty, when the too feeble mind can no longer co-ordinate remembrances and feelings, the accumulations of years. The character of the hystericals is no other than the character of feeble minds, that of children.

If we try to extract from the preceding descriptions traits of character which are not found so clearly in all weak minds generally, and which belong solely to hysteria, we shall observe especially two particular traits: the character is *mobile* and *contradictory*. The patient

does not remain long in one and the same moral condition. She passes every moment from affection to indifference, from gladness to sadness, from hope to despair. She seems to be in an unstable equilibrium and to fall every moment from one side to the other. On the other hand, there is not a single trait of character that is not every instant contradicted by some action apparently wholly different. Hystericals appear unintelligent and very lively, apathetic and emotional, hesitating and stubborn. These two characteristics should no longer surprise us, since they have been described in all the chapters of this book. They have always, we think, the same meaning. They show the want of mental unity, the diminution of personal synthesis, and the conservation of the automatic phenomena which reappear with exaggerated development.

This mental state is, then, manifest in the character and the emotions, as well as in the sensations and remembrances; but it appeared to us much clearer in the precise phenomena which have been separately studied. It is through the study of mental stigmata that the malady of hysteria must be diagnosed and understood. Each of them shows us very well that the subject has sustained a loss in his personality and that he is no longer master of his own thought.

PART II

MENTAL ACCIDENTS

CHAPTER I

SUGGESTION AND SUBCONSCIOUS ACTS

WHEN we examine the demeanour and thought of certain patients, particularly hystericals, we soon discover that their thoughts are not like those of other people. While with others ordinary ideas, sensations called forth by the sight of surrounding objects or accidental conversations, retain some sort of normal calm — their balance, so to say, along with other psychological phenomena—with hystericals it is otherwise. One particular notion will all at once assume an undue importance, —an importance altogether out of proportion to their other ideas,—and play a chief part in their lives. This fact has been often observed and pointed out by students. They endeavoured to describe and explain the case in various ways, accounting for it as happening at certain periods of the malady; at one time they explained it by the action of the *morale* on the *physique*, of mind on body; now, again, they describe the *power* of the *imagination; at the present day*, they employ the word more in use, "suggestion"—borrowed from the hypnotists. The knowledge of these suggestions, artificially called forth, seems to us the necessary introduction to the study of fixed ideas, naturally developed. We shall especially endeavour to distinguish suggestions from all that has often been confounded with them, and shall try to recognise the conditions in which these phenomena are produced.

§ 1—DESCRIPTION AND CLASSIFICATION

Many philosophers, and most of the former magnetisers, among whom we find observers of great merit, have very well pointed out this preponderance of certain ideas, mentioned above. We cannot repeat here the descriptions of the Puységurs, the Deleuzes, the Braids, the Charpignons, etc., nor take up again the history of suggestion which we have already given elsewhere[1]; it will be enough to repeat the conclusion: "All the phenomena, without exception, pointed out as new in the works of modern hypnotism, can be found in the numerous examples given by the French hypnotists, especially in those published between 1850 and 1870."

Among the subjects treated by these authors, many, no doubt, were hystericals; only it is somewhat difficult at times to make this retrospective diagnosis. In other books, again, where the pathological character of the subjects is more evident and better understood, we find also numerous descriptions of suggestion. No one now will deny that the possessed, who in former times rolled on the floor in convulsions, and bent before their priests, were hystericals; and we may consider the accounts given of the exorcisms of that time as a *bona-fide* description of a suggestion. For instance, you tell the devil: "Stretch out the right leg of this woman," and it will be stretched out quite stiff. A grave Sorbonne doctor will say to the fiend, "Make her feel cold about the knees," and the next moment the woman will complain of very great cold. He will be told to make seven times the sign of the cross with her tongue, and it will be done, etc.[2]

Facts of this kind are described in many an old book,[3]

[1] *Automatisme psychologique*, 1889, pp. 141, 245, 271.

[2] Don Calmet, *Traité sur l'apparition des esprits et sur les vampires*, 1751, i., p. 212.

[3] Beauchêne, *De l'influence des affections de l'âme* . . an vii., p. 141; Demangeon, *De l'imagination dans ses effets sur l'homme et les animaux*, 1829, p. 58.

but to understand the true nature of these phenomena we must come down to more recent periods. M. Brodie, in 1837, demonstrated of what importance certain ideas were in the mind of the hysterical; M. Despine, in 1840, exhibited in an hysterical woman, Estelle, all kinds of automatism, especially *mirror imitation;* "the hand of the patient opposite mine followed every movement of my own hand."[1] Russell Reynolds, 1869, studied the paralyses "*dependent on ideas.*" M. Hack Tuke, in 1872, and M. Ch. Richet, in 1875, have given numerous examples of suggestions made to neurasthenics. M. Charcot especially, in his great lectures of 1884 and 1885 on hysterical monoplegias,[2] described the theory of these phenomena; he pointed out a great number of paralyses and contractures occurring among hysterical patients in consequence of an emotion or a "*shock,*" and showed their true nature by reproducing them artificially on other subjects. Subsequently, M. Paul Richer in hystero-epilepsy (*La grande hystérie*) 1885, and all the authors who have mentioned these patients have clearly brought out their remarkable suggestibility. M. Gilles de la Tourette, in his recent work, describes the whole mental state of hysteria in one word: *Suggestibility.*[3] We are disposed to be less sweeping in our assertion, for we believe that there exist in hysteria a number of mental states which are anterior to suggestibility.

Originally the studies on suggestion were made when the patient was in a somnambulic state; but a number of authors now hold that, with some subjects, suggestion may occur without its being necessary to induce

[1] Despine (L'Aix). *Le magnétisme animal dans le traitement des maladies nerveuses,* 1840, p. 144.

[2] Charcot, *Mal. du syst. nerveux,* iii., p. 342.

[3] Gilles de la Tourette, *Traité clinique et thérapeutique de l'hystérie,* 1891, p. 492.

somnambulism. M. Ch. Richet in 1882,[1] M. Bernheim, in 1884,[2] M. Charcot, in 1885,[3] described a number of examples of suggestion during the patient's waking state. We are convinced that this fact is quite common among hystericals.[3] This observation, most important for the understanding of hysteria, assists also the study of suggestion. It enables us to distinguish, almost completely, suggestion from somnambulism, and to study it by itself during waking hours. All the suggestions of which we shall speak in this chapter, unless we make a special exception, will, then, be made in waking hours. The idea whose abnormal and exaggerated development we wish to study will be conveyed to the patient by whatsoever means of expression may be at hand; usually by word. This experimental reproduction of dominating ideas in hysteria enables us to classify such ideas and to treat them seriatim.

It is difficult to classify all the phenomena that can be produced by means of suggestion; for, in the first place, they are innumerable and extremely varied, and, in the second, they intermingle constantly without presenting any decided differences. The way of enumerating them is to arrange them according to their order of increasing complexity and to distinguish: 1st, *negative suggestions;* 2nd, *positive elementary suggestions;* 3rd, *complex suggestions;* 4th, *general suggestions.*

1st. *Negative suggestions.*—With very sensitive subjects we may by a certain process, a simple affirmation, suppress, with apparent completeness, psychological phenomena which before seemed normally produced. You may induce, artificially, anæsthesias of various kinds,

[1] Ch. Richet, *Bulletin* de la Société de biologie, 1882, p. 21. *L'homme et l'intelligence*, 1883, p. 523.

[2] Bernheim, *De la suggestion dans l'état hypnotique et dans l'état de veille*, 1884.

[3] *Automatisme Psychologique*, 1889, p. 173.

amnesias, paralyses, and other phenomena analogous to the ordinary stigmata of hysteria.

If you convince the subject that he no longer feels, that he has lost the use of his senses, you will see all the forms of anæsthesia appear; the subject may be wholly insensible, may be blind and deaf, and this insensibility may be so great that violent excitations, pricks, or burns, provoke no longer any reaction. For example, a strong light directly projected into Lucy's eyes usually induces catalepsy. When we tell her that she is blind, she does not even look about her to see if it is so, but continues in what she is doing with perfect indifference. This experiment recalls that of MM. Binet and Féré, who, by suggestion, annulled the noise of a gong, which was no longer troublesome to their patients. When the skin has thus been made insensible, it sometimes happens that the hysterogenic points have also wholly lost their ordinary power; sometimes, however, the pressure exercised on those points, although not felt by the patient, nevertheless brings on the attack. These suggested anæsthesias may also take a localised form; you may, for instance, draw, on an arm of ordinary sensitiveness, regular squares, and assure the patient that within these squares she has no longer any feeling. Although her head is turned away and she has not seen the place where she was pricked, she will complain every time she is pricked outside the square and will feel nothing when pricked within it. Lastly, suggested anæsthesias may be systematised, and deprive the subject of a certain number of sensations or images, allowing the knowledge of all the other phenomena to come to his consciousness. This very curious experiment has been the subject of a large number of studies made by old magnetisers as well as modern hypnotists.[1] At the beginning of our studies on anæsthesia, we formerly described a great many

[1] See the historical report of this question. *Autom. psychol.*, p. 271.

observations on this point.[1] It is useless to repeat them here, for they are rather psychological than clinical researches. Amnesias may be produced in the same way as anæsthesias. We could undoubtedly provoke general amnesias, although it has been rarely done. Usually we suggest to the patient to forget a period of her life or certain particular events. We have known an hysterical patient who for fifteen years had forgotten some important events of her life, the remembrance of which had been suppressed by a hypnotist. Systematised amnesia is particularly interesting here, as it presents a subject who, preserving all his intelligence, may forget an act, a word, his very name, while he remembers all the other details connected with a certain case.[2]

In fine, it is quite natural for various paralyses to be suggested; they are only different phases of the preceding amnesias. We know how Professor Charcot in his lectures of 1884 produced on hysterical patients when fully awake — Hal., for instance — experimental monoplegias in order to demonstrate the real nature of the traumatic accidents of Pin and Porcz. M. Charcot observed very correctly how these suggested paralyses may differ in aspect and, according to the subjects, be accompanied or not by tactile or muscular anæsthesias.[3] We have, in fact, seen it produced alone sometimes, without anæsthesia. This will occasionally happen in natural paralysis through traumatism. There has been this year an example of this kind in the service of the Salpêtrière, but it is extremely rare. Professor Charcot has minutely described the general form of these suggested monoplegias; they are accompanied by a tactile and muscular anæs-

[1] "Anesthésie systematisée et la dissociation des phén. psychol." *Revue philosophique*, 1887, i., p. 449.

[2] Ch. Richet, "Expériences d'amnésies." *L'homme et l'intelligence*, 1884, p. 539. Paul Richer, *La grande hystérie*, 1885, p. 740.

[3] Charcot, *Mal. syst. nerv.*, iii., p. 353.

thesia of the whole member, limited by a line nearly circular and perpendicular to the axis of the member.[1] Things happened this way with several subjects to whom we made this suggestion for the first time.

The old magnetisers had already discovered that a subject may be prevented from making a particular movement, pronouncing a certain word, or writing a certain letter. A certain person, for example, cannot write the letter *a*; he skips it when he writes his name.[2] It is easily understood how a patient who can perform with her arm all possible movements except those that will make an *a*, is like her who can see everything around her except the particular person pointed out for her to see.[3]

All these phenomena produced by negative suggestion resemble very much the natural stigmata of hysteria. One should not, however, too readily regard this close resemblance as an absolute identity.

2nd. *Elementary positive suggestions.*—An idea suggested by word, instead of suppressing real psychological phenomena, produces and increases them. We may thus suggest attitudes and movements, command a patient to raise his arm and keep it up, or repeat indefinitely some oscillation or other. He will do so without being able spontaneously to stop the motion; in some cases a real contracture may result. This phenomenon resembles somewhat the partial catalepsis we have already studied; really, the psychological differences are quite marked. One does not observe here, except by special training, either the same anæsthesia[4] or the same immobility without fatigue, or the same unconsciousness. One can also by this method call forth a new phenomenon, namely, hallucination; the subject expresses by his attitude and

[1] Charcot, *Mal. syst. nerv.*, iii., p. 348.
[2] Dr. Philips (Durand de Gros), *Cours de Braidisme*, 1860, p. 120.
[3] *Autom. psychol.*, p. 146.
[4] Pitres, *Leçons cliniques sur l'hystérie*, ii., p. 348.

speech that he experiences from these suggestions all sorts of false sensations. You make him thus hear the sound of bells, songs, a flourish of trumpets; you make him see flowers, birds, smell odours, taste various things, raise imaginary weights, etc. In a word, you evoke in his consciousness all the phenomena which generally correspond with the real impressions made on the different senses. These hallucinations are usually as strong as real impressions. Sometimes, again, it is the contrary; the hallucination will apparently seem weak, will have rather the effect of a faint remembrance than a false sensation. "In somnambulism and hypnotism," says M. Taine,[1] "the patient that has become very sensitive to suggestion is subject to similar illusions of the memory; you declare to him that he has committed a certain crime and his face will express all the horror and fear which the actual fact would call forth." Suggested movements and hallucinations are phenomena which go together, so to speak, and present a parallel development.[2]

3rd. *Complex suggestions.*—These suggestions are rarely as primitive as the foregoing; they contain nearly always a certain number of images and movements. If you suggest to Bertha that she is at a ball, she ceases to see the room she is in and the objects it contains,—this is the negative part of the suggestion; she sees instead a ball-room, a great many people, a variety of costumes; she laughs, bows to this one, to that one, dances, etc. There is developing here in her mind a considerable number of psychological phenomena. You will find in the various works on this subject numerous examples of these suggestions spontaneously developing each other. This is why these mimic dreams are often so amusing in the case of a lively and intelligent patient. We will emphasise only one point—namely, the close connection which exists.

[1] Taine, *Intelligence*, 3rd edition, 1878, ii., p. 222.

[2] *Autom. psychol.*, p. 148.

between the different elements of these dreams. When, after an interval of a few days, you repeat to your patient the same suggestion, the same scene will be enacted; the same moment will reproduce the same acts and the same words. There is thus interwoven a series of facts in an almost indissoluble manner.

This union of different phenomena will sometimes bring about curious facts which have been often pointed out: chills, nausea, and even vomiting have been shown to form an integral part of these dreams. They are provoked by certain images and indicate certain hallucinations by the motions of the mouth, the nostrils, and the eyebrows. The sensibility or insensibility of the cornea, of the movements of the pupil, even, indicate the kind of hallucination the subject is under when he thinks he is looking at what is near or remote.[1] The whole organism as well as the whole mind seems to take part in the suggestion. From this association of images in a complex suggestion, there results an extremely grave phenomenon, that suffices to start in the mind of the subject one of the terms of this series for all the others to follow regularly in its wake.

Now in such complex suggestions, whether they are intended for a purpose or happen by chance, there enter often real sensations which form a part in the chain of phenomena. A pain in a limb, the sensation of a shock, is in this way associated with the idea of illness, fracture, impotency; and M. Charcot demonstrated a few years past and at a time when these psychological phenomena were much less known than they are now, "that it is possible to produce paralysis in the arm of a suggestible patient, not this time by means of a command, but by interposing an agent similar to the one which determined the monoplegia in both Porcz and Pin—namely, by nothing more than a blow on the shoulder.[2]

[1] Féré, *Arch. neurol.*, 1882, i., p. 286.

[2] Charcot, *Mal. du syst. nerv.*, iii., p. 354.

If we tell Mary that when the clock strikes she will see a butterfly cross the room, or a bird on the window-sill, she will perceive the butterfly or the bird only when the clock strikes, and only on the window-sill and nowhere else. Any word said, any sign made, any part of the body touched, becomes incorporated in the whole of the suggestion. Henceforth, in order to call up this particular sensation, it will be enough, voluntarily or involuntarily, to touch any one link, and the remainder of the suggestion will unroll before you, to the great astonishment of the operator, who will fancy that he is discovering a manifestation of a very extraordinary physiological law. Again, if, at the moment when you start in the mind of your patient gay images, provoking laughter, you press upon a particular part of the body, you will discover that your patient will laugh every time you touch the same spot; it is well, on this account, to avoid inventing ideogenic points. These sensations, which are a part of a complex suggestion, and which by their presence alone bring about its development, have received a very characteristic name: they are called *points de repère*, marked points, and the suggestions in which they appear, marked-points suggestions (*suggestions à points de repère*). They are among the most important things, both for the production and for the explanation of certain facts. We hold that it is impossible to understand anything in the various accidents of hysteria if this phenomenon be not constantly kept before the mind. We have shown here only examples borrowed from artificial suggestions. Here is now a well-known experiment, which is explained as follows: You show to a patient an imaginary portrait on a card seemingly all white; you then mix up this card with several others; the patient will almost always find the portrait again on the same card which has first been shown to her, and in the same position; she probably recognises the paper by some small characteristic differences. In

fact, the patient blunders so soon as you select very similar papers and avoid rumpling the one you present to her.

MM. Binet and Féré, in their very original experiments with the eye-glass, the mirror, and the prism,[1] have shown that if the marked point (point de repère) varies in any way, if it increases, diminishes, undoubles, the hallucination will correspond therewith. If you show Lucy a snake wound around the lamp, she will see in the mirror a second snake as well as a second lamp. We have given elsewhere many other examples of the same phenomenon. We recall them here only to show their great practical importance.

4th. *General suggestions.*—We give this name to a last degree of complication in suggestion. The psychological phenomena which compose it become so numerous that they fill the mind completely and transform it wholly. An example may take the place of a description: Margaret is a young woman twenty-three years of age, who has been at the Salpêtrière for more than a year, and who consequently knows us all very well. She has had a series of hysterical accidents, contractures, blue œdema—in short, attacks which have made her very ill; she shows all the stigmata of hysteria; on the right side, complete anæsthesia, which prevents her moving her right arm unless she sees it, and which she keeps in cataleptic postures; if we move it without her knowing it, there will be shrinkage of the visual field to 35°, etc. Well, we simply say to her, emphasising her first name, Margot: "Good morning, Margot." She starts and changes countenance. As she looks at us, somewhat bewildered, we ask her what is the matter. "What ails you?"

"Sir, I do not know you."

"Nonsense. You saw us a little while ago; this very morning."

[1] Féré, *Archives de neurol.*, 1882, i., p. 295. Binet et Féré, *Le magnétisme animal*, 1887, p. 167.

"No indeed, sir, for this morning I was at school, attending to my lessons."

Surprised at these replies, we look at her more attentively and perceive that she has completely forgotten where she is,—at the Salpêtrière,—forgotten her disease and all that she did these past years, and that on the contrary she remembers her childhood with astonishing accuracy. We ascertain, moreover, that she has no longer any hysterical stigmata. She cries the moment we pinch her right arm; she moves it without looking at it and retains none of her cataleptic postures; her visual field has, moreover, become absolutely normal. What, then, has happened? You have but to ask her her age. "I am eight years old," she will say. All is explained; the word "Margot" was the name given her at school when eight years old, and this name is the word which awakened in her mind the many remembrances and images and even sensations with which it was connected. Even the tactile and muscular sensibility of the right side, which seemed to have disappeared from her consciousness, but which, as we know, existed there in a latent state, awoke, and reconnected itself with her personal consciousness to reconstruct the whole Margot-system when eight years old at school.

We have shown that it is sometimes possible to carry patients back to different periods of their lives, and note all the different stages of sensitiveness, as well as their causes, through which they passed. M. Pitres[1] has given great attention to a state of delirium which he calls *délire ecmnésique*, in which the subject seems to live over again a period of her former life. He has also demonstrated that the stigmata of hysteria, present in the patient, disappeared during the period of delirium, and that the subject, wholly transformed, resumed an anterior psychological state.

[1] Pitres, *Leçons cliniques sur l'hystérie*, ii., p. 293.

We may also connect with these general suggestions the modifications of the personality which the hypnotists are fond of reproducing at their séances and which M. Ch. Richet [1] has so ably described. The subject, according to the dream suggested to him, becomes transformed into a preacher, a general of an army, etc. These, of course, are the same phenomena alluded to above; but they have grown and have gradually transformed the whole mind of the patient.

We shall not describe here the physiological effect suggestions may have, such as rubefactions of the skin, burns, blisters, which are as real as they are strange,[1] and the study of which will probably bring to us later the knowledge of the organic and visceral phenomena which are so often observed among hysterical patients. We have to confine ourselves in this work to the examination of their mental state alone.

This rapid review of the phenomena of suggestion has shown us facts apparently very different from each other; they all have, however, the great characteristic indicated in the beginning. These ideas, accompanied by acts, hallucinations, complex dreams, modifications of the whole personality, took evidently in the mind of the patient an unduly significant place. They went beyond the mark; they obscured the other thoughts normally developed. This description enables us to establish, if not to understand, the suggestibility which is so general and so unmistakable a symptom among hysterical patients.

§ 2.—PSYCHOLOGICAL CHARACTERISTICS OF SUGGESTION.

Have suggestions any psychological characteristics of their own? Should they be distinguished from the other

[1] Ch. Richet, *L'homme et l'intelligence*, 1883, p. 233.

[1] *Autom. psychol.*, p. 165.

phenomena that take place in the human mind? Some authors have altogether denied this; they have contended that suggestion was in some respects a moral factor, and that there was no distinction to be made. "I define suggestion," says M. Bernheim, "as follows: It is the act by which an idea is introduced into the brain and accepted by it."[1] "All that enters into the mind, by whatsoever sense, all that is called forth by associations of ideas, by reading, by teaching; all that is invented by the subject himself; all beliefs, whatever be their origin — all is suggestion." "Every reasonable man," said M. Babinski[1] on this point, "would thus be constantly under the influence of a suggestion." This mode of talking about these things need not be regretted. It served to bring into relief the psychological and moral character of the phenomenon, leaving aside all other details. But, on the other hand, is it not dangerous to take thus the word "suggestion" as synonymous with the old general terms for "thought, psychological phenomenon, consciousness"? Is it well to take no account of the distinctions established for centuries by the philosophers, between the diverse psychological phenomena, sensation, imagery, association of ideas, judgment, will, personality, etc.?

There is another disadvantage, still more serious, to be pointed out in this confusion of words, which is that there exists a very precise phenomenon, quite distinct from other psychological facts, which has been designated by old hypnotists and alienists by the word "suggestion." This phenomenon must not be confounded either with recollections or with ordinary associations of ideas; it has its special characteristics and, above all, its very particular and very grave consequences. If the word "suggestion" is already employed to designate

[1] Bernheim, *Hypnotisme*, 1891, p. 24.

[1] Babinski, *Gazette hebdomadaire*, juillet, 1891, p. 21.

some idea or other, penetrating, no matter how, into the mind, it can no longer clearly characterise this special phenomenon. One becomes, then, aware of the most astonishing confusions: under the same name will be described the lesson of a professor to his students and the hallucinations called forth in an hysterical patient. The characteristics observed in one of the factors will be attributed to the other, and *vice versa*. It will no longer be possible to distinguish the mental disease, which is nevertheless a sad reality, from the normal psychological state.

If we reserve the word "suggestion" for such factors as have been described above, it will be very easy to see that they are not psychological factors absolutely normal and identical with all the others. These paralyses, these impulsive movements, these hallucinations, following upon a single word, are not to be found in our ordinary thoughts. Even with persons most suggestible, suggestion is not a perpetual thing, and may be very well distinguished from other thoughts. With a little practice, it will be very easy to see, by merely looking at her, when Margaret is beset with a suggestion, or simply engaged in her ordinary mode of thinking. Although Bertha is very quick to take suggestion, you may, nevertheless, talk with her quietly and relate to her many things without her having hallucinations every minute. The close observer will easily notice that there is among these women a well-defined difference between what is suggestion and what is not. Again, the subject herself notices this sometimes and is able to distinguish between suggestion and other moral factors. Justine is very sensitive to suggestion and to hallucination, and yet when we try a suggestion with her, it sometimes happens that she answers us in a very commonplace but quite characteristic way: "Sir, I do not know the reason, but the thing does not take."—"How—what do you mean? You did

not understand what we said ?"—" Not that; I understood quite well."—" Then you do not wish to do what we ask; you do not accept our proposition ?"—" I, sir, I accept all; I am quite ready to obey you, and I will do all you bid me do, only, I tell you beforehand, that the thing did not take." With the preceding definition of suggestion, these answers of the patient would have no meaning; the idea, having penetrated into the mind and having been accepted, should have been accounted a suggestion. Yet the patient was right; she has experienced suggestions, she knows what they are, and although she accepted the new idea willingly, and with absolute confidence and obedience, yet she felt that things were not proceeding as usual, and that it was not a suggestion. The resemblance which exists between suggestions and fixed ideas is well known; now, patients with fixed ideas speak in the same way. V., generally very much tormented by her obsessions, had been obliged for several days to nurse her husband, who was quite ill: " I was," she told me, " wild with uneasiness; I thought night and day of a possible misfortune."—" Tormented as you used to be by your former ideas ?"—" Why, no; how can you compare the two ? It is quite another thing." Suggestion must, then, have characteristics of its own, since it is so easily discerned.

Unfortunately our feelings are often vague, permitting us to distinguish things without being able to say wherein their difference precisely consists. This is the difficulty with scientific analysis, when it is a question of delicate phenomena. We do not pretend to be able completely to analyse the very curious fact of suggestion, nor to distinguish it clearly from those other phenomena so little understood,— belief and voluntary act,— but we should like to point out the problem in such a way that others may later solve it more satisfactorily.

In the foregoing descriptions, suggestion is presented

as a psychological phenomenon of great importance. It is sometimes possible to indicate exactly what has given this apparent character to the phenomenon. In some observations, the *duration* of the phenomenon has seemed to us abnormal and disproportionate to the time similar phenomena usually occupy. Elsewhere we have been struck with the *frequency of the repetitions*, the fact reproducing itself anew every moment; while in normal conditions it would have taken place only a few times. In these repetitions there is to be noted the *regularity* which brings with it the *rhythm* and *periodicity*. These very interesting peculiarities are characteristics of elementary physiological and psychological phenomena, and are not found again in the same degree in acts properly called voluntary. There is also to be noted the *facility* of these reproductions of the same phenomenon; it would seem that it requires but the touch of a spring for a number of quite complicated actions to take place without effort on the part of the subject. Men of science have particularly dwelt on the astonishing *rapidity with which the idea passes into the act*. The reflexions, hesitations, which stop us generally when at the point of carrying out an idea, have completely disappeared. In short, we see that those ideas are always accompanied by a sense of *conviction*, and this to such a degree that they always appear to be *objective*. They become transformed, as it were, into objects and seem to be a part, not of the inmost thought, but of the exterior world. However, these characteristics show us only a distinction of degree, and not a real, natural difference.

Let us, then, take up again the study of the different facts of suggestion, beginning with negative suggestions. If we take as an example the curious suggestion of systematised anæsthesias we find that the subject seems to have completely lost sight of a certain object he had been forbidden to see, but the simplest investigation

will show that this blindness is only accidental and that it is far from being absolute.[1]

We have applied ourselves to show how this persistency of sensation, despite systematised anæsthesia, was always necessary and incontestable.[2] Here is now an experiment among many others: we place on Lucy's knees twenty slips of paper, all of which are numbered; "You shall not see," we say to her, "the papers that have multiples of three."

After a little while, when the suggestion seems to "have taken," we tell the subject to hand us, one after the other, the papers which lie on her knees. She hands us fourteen and leaves six, which she takes good care not to touch. The six remaining ones are the multiples of three.

The patient pretends not to remember that we had given her a command and not to see anything on her knees; yet it is nevertheless necessary to remember the question of multiples of three, and see the numbers in order to recognise the papers that bear the multiples. It is useless to recall here all the other experiments of the same kind by means of which we have been able to show the general character of negative suggestions. Whether the question is anæsthesia, even general, amnesia, systematic or localised paralysis, there is always a certain portion of the sensation, memory, motion which, despite negative suggestion, has been completely preserved. This observation no longer surprises us, for it has already been studied in respect to all the stigmata of hysteria, and that part of the phenomenon which is preserved is well known; it is the sensation or the simple, elementary image, the subconscious psychological phenomenon; what has been altered in the negative suggestion is the

[1] Binet et Féré, *Magnetisme Animal*, 1887, p. 236.

[2] "L'anesthésie systématisée et la dissociation des phéno. psychol.," *Revue philosophique*, 1887, i., p. 457; *Autom. psychol.*, p. 276.

synthesis of the psychological phenomena, their reunion to the notion of personality. One day we suggest to Leonie *not to see* M. Gibert, who is entering the room. Our suggestion does not wholly succeed, since she *sees him enter*, yet there was nevertheless a certain effect of the suggestion which is very curious: she does *not recognise him*, and takes him for someone she has never seen. What is non-recognition? Evidently the fact that the actual sensation is not reunited to the innumerable recollections, sentiments, etc., which that person really possessed in regard to M. Gibert. When the suggestion goes farther and suppresses even conscious vision, the phenomenon still remains of the same kind; only the lack of synthesis is still more accentuated. Not only is the new sensation not reunited to certain determined recollections, but it is not reconnected with any of the sensations which, at this moment, constitute the personality of the subject. It is for this reason that the subject says, quite justly: "*I do* not see; *I* do not remember; *I* cannot move."

There are, then, two great psychological characteristics of negative suggestion: 1. *Preservation of subconscious and automatic phenomena;* 2. *Diminution or suppression of the synthesis which constitutes personal perception.*

We shall find, again, the same characteristics, still more distinctly, in studying the other kinds of suggestion: 1. *Development of elementary phenomena.* In a small number of extremely simple suggestions,—as, for instance, when one is satisfied with keeping the arm of a subject up,—one may say then that there is but one psychological phenomenon called up in his mind. It will already have its particular character—namely, the tendency to be prolonged, to remain as long as possible with the arm in that position which corresponds to the phenomenon.[1] But in the immense majority of cases a suggestion is a

[1] *Autom. psych.*, p. 55 and following.

complex phenomenon, and its first characteristic is that it consists in the automatic development of all images contained in an idea.

Any idea, well understood, quite clear, forms in reality in our mind a whole, a system of different images, each having special properties diversely co-ordinated. Let us take for example this very simple thought expressed by the words, "Go around the room." This thought contains visual or muscular images, as the case may be; there are an implied movement of the limbs, visual images of a new aspect of the room at the moment of leaving it, then other motor images and other visual images of a new room, and thus a long succession of varied representations until you come to the last, which reproduces again the first aspect of the room. The thought of a bouquet of roses or the thought of a cat contains alike numerous elements grouped around each other in a very close dependency. We have but to point out in these ideas the notion of the colour of the flowers, the colour and form of the cat, then numerous images of smell, touch, hearing, etc.,—in a word, as we were saying, these ideas are veritable systems of images. Oftenest, these systems are reproduced in our mind in part and abridged; for instance, the sonorous or kinæsthetic image of the word "flower," or of the word "cat," will alone be reproduced, or nearly alone, and will be sufficient to represent the whole complex system of which it is but a small element.

In the cases of suggestion, which we are endeavouring to analyse, we see, on the contrary, that systems of this sort, if they once begin to develop in the mind, do not remain incomplete. All the component details, visual images, tactile images, kinæsthetic images, reappear in their place so as to reconstitute the system in its entirety.

All suggestions, from the simplest to the most complicated, are of the same kind. If you cause an extremely

suggestible patient to clench her fist she will get angry; if you fold her hands she will kneel down and begin to pray. This is because these two sensations, the clenched fist and folded hands, are elements of great systems of thought—systems formerly constructed. These systems constituted the emotion of anger and the religious emotion, and to-day it suffices to start into being one of the elements for all the others to reappear under the form of images, and re-establish the primitive emotion with its expressions and its movements. If we say before an hysterical person, "A bouquet of roses," the sensation of sound which she perceives will not remain in her mind alone. It is but the first boundary of a series of images, which have already been associated together to constitute this idea. The subject sees the roses, their form, their colour; he smells them, he fancies that he touches them, he pricks his fingers with the thorns, etc. Is it to be wondered at that he believes in the reality of this bouquet, that he believes in its objectivity? But this belief with everybody depends in a great measure on the complexity of the images which are part of a thought. "Our usual representations," writes M. Souriau, "seem to us internal because they are much more complex than the external perceptions."[1] Hallucination, the belief in the objective reality, as external motion, depends on the development of the images contained in an idea. With still greater reason we may say that it is the same with general suggestions; the question here is a complete system of thought which, by being realised, transforms momentarily the whole mind. The great importance which we have proved in suggested ideas may now be understood; the duration, the repetition of these ideas, their transformation into acts and hallucinations, are consequences of the same phenomenon. *An organised*

[1] Souriau, "Sensations et perceptions," *Revue philosophique*, 1883, ii., p. 175.

system of former images is now reproduced; *its tendency is to live—that is, to last and completely to develop itself.*

2. *Diminution of the personal synthesis.*—Suggestions present a second characteristic, complementary to the first and quite as important. This development of all the terms contained in an idea is not only complete, it is also *automatic;* it is but *the repetition of former ideas* and is brought about *without the subject's having a personal perception of it.* If we examine very clear cases of suggestion, and it is evidently those which should be first examined, we are struck with their mechanical regularity. If the same suggestion is repeated several times, even at long intervals, the acts, the words, the attitudes, of the subject are always exactly the same. The subject takes the same number of steps, does not modify his gait in any way, even though the external circumstances have much changed. If we speak to Léonie, who is nearly fifty years old, and suggest to her that she is a princess, she will begin to fan herself, spread out "her beautiful black velvet gown," turn to the marquis of Lauzun, etc. Now these are exactly the same words she said *thirty years ago*, when Dr. Perrier (of Caen) gave her the same suggestion. Exactly the same images are unrolled in her mind, without any originality or any recent invention on her part.

If we consider new suggestions responded to by the subject for the first time, we find still the same characteristics. The subject, in respect to the new suggestion, will reproduce some former idea, and will reproduce it just as he acquired it, without any modification. If we make to two different persons, Léonie and Lucy, the same suggestion, if we make them believe that they are changed into priests, we shall see that they do not compose their part, so to speak, but that they recite it. Each will show how she formerly conceived the idea of a priest; one is serious, grave, and speaks in an unctuous

tone; she blesses the persons around; the other makes faces and wishes to drag penitents to the confessional in a very unorthodox manner; it is the mechanical reproduction of an old idea.

Automatism manifests itself still better when we examine the manner in which the subject is conscious of the suggested act. We shall see that he accounts for it very badly; that he does not understand it, and that he does not at all connect it with his personality. The first fact that has been noticed is that most suggestions are completely forgotten immediately after their being carried out.[1] Isabella went after her bouquet of roses, Bertha went to play with her little dog Finaud, which we suggested to her she would see in her arms, and Margaret thought herself taken back to her boarding-school. After a few minutes these dreams spontaneously ceased or were interrupted by us; the subjects had sometimes a slight shock, as by a sudden awakening, and took up again their normal existence. At this moment one cannot obtain from them any information concerning what has just been taking place; they remember nothing, and if you insist on the thing, they absolutely refuse to believe that they had experienced the aforesaid hallucinations. Of course, we well know the nature of this amnesia; we know that recollection may momentarily be recalled by another suggestion, or by a great effort of attention; we know that this recollection may be manifested by all sorts of subconscious acts. It is, however, not the less incontestable that the subject has not spontaneously the personal perception of this recollection; that he has not connected the suggestion with his own personality.

But let us examine these suggestions at the very moment of their execution and we shall see the same absence of personal perception in a still higher degree. Bertha caresses her little dog Finaud, which she believes

[1] Beaunis, *Le somnambulisme provoqué*, 1887, p. 121.

to be on her knees; she seems to be in her usual state of consciousness; she talks to her dog and appears to have a certain mental activity. But it is only an illusion; if you examine her closely you will notice at first that she is no longer in a state of normal sensibility, that, instead of being only anæsthetic on the left side of her body, she has become wholly anæsthetic. Her eyes seem to be devoid of sight, for she cannot distinguish any object placed before her; her ears do not appear to hear, for the persons who speak to her do not succeed in obtaining any answer. We ourselves cannot without difficulty get her to listen to us, perhaps because, having given the suggestion, we are to a certain degree a part of her dream. But we get queer, incoherent answers; Bertha can no longer tell us her name, nor her age, nor her costume; she does not know any more where she is; she does not remember anything at all. In a word, the totality of sensations and recollections which constituted her personality seem to have disappeared, or rather there seems to be no longer any personality at all. There is in her mind but one thing left, namely, the all-dominating, solitary idea of the little dog Finaud. We should not be surprised if presently Bertha had no recollection whatever of this dream, because she was really not present in it. These characteristics are perhaps a little clearer with Bertha, but they exist in most hysterical patients; *suggestion is connected with the personality neither by recollection when it is over, nor by conscious perception while it is being performed.*

These two characteristics, the repetition of the past and the absence of personal perception, may be considered the signs of automatism opposed to voluntary activity.

Will, undoubtedly, is very difficult to define, and involves all sorts of philosophical problems, but it can practically be recognised by the two following traits, which have already been studied in regard to abulia: A volun-

tary act is an act, at least to some extent, *new*, which, to adapt itself to new circumstances, reunites, synthesises certain psychological elements not as yet exactly grouped in that manner. It is, in the second place, a conscious and personal act; this act is in every respect connected with the idea we have of our personality:

> It is I, we say, who, before executing it, have foreseen this act; it is I who, at the moment of accomplishing it, feel that I am performing this action; it is again I who later keep the remembrance of it. I connect it in every respect with my character, with my sentiments and with my ideas; I consider it henceforth as an integral part of my personality.

An automatic phenomenon has the two following opposite characteristics: it is essentially constituted by an association of images which reproduce themselves regularly, one after the other, in a certain fixed order. But this order is not new; this regular juxtaposition is only the result of the synthesis, executed formerly, which once for all co-ordinated these elements and gave them this tendency to call each other forth. Besides, this phenomenon is not conscious in the same way as the voluntary act is; we do not in this instance say: "I, me, Mr. So-and-so, I make the motion of walking, eating, writing." It calls forth only isolated phenomena of consciousness, and does not come within this perception of a whole, which is called personality. In normal life these two categories of phenomena are constantly found mixed; no act, certainly, is entirely voluntary, but neither is there one wholly automatic. We have remembrances, habits, which are the reproduction of past acts; but these phenomena are not developed freely nor completely. Unceasingly the personal and actual consciousness watches, arrests, or modifies the old automatic activity and puts it into relation with new circumstances. Men have, on this point, very different powers of thought;

many think like old people who live more in the past than in the present; many do not know how to struggle against the ideas that have struck them, and accept them with very great facility, but as long as they are not insane they retain a certain power of personal perception over present things; they endeavour to bring ideas, too quickly accepted, and the perception of reality into a certain harmony. Our moral health depends altogether on the limitation which these two psychological activities exercise upon each other; it is on this equilibration between the automatic force of the past and the conscious and voluntary effort of the present that sanity depends. That which characterises the dream, the delirium, is the destruction of that equilibration. Many psychologists have been struck by this characteristic:

> Dreams [says M. Macario] have a great analogy with absence of mind, which is, so to speak, to dream in a state of waking. Both flow from a series of ideas which are born and spring up *mechanically*, *without the mind paying any deliberate attention to them*, and arise from the confusion and disorder which is discovered in these *two passive* states of the mind.[1]

We think it is the same in regard to suggestion.

That which characterises suggestion is, that this necessary equilibration is here entirely broken. We must not look upon certain cases of voluntary obedience, of compliance on the part of the subject, as cases of suggestion. When we say to a poor sufferer, very humble before us, "Come now, friend, think of getting well; think that you are cured; shut your eyes; pretend to sleep," this patient will do all that we wish him to do, and he will do rightly, but it is a voluntary compliance, altogether reasonable, altogether in harmony with the desires, the personality, and the present situation of the patient. This docility, this confidence, is certainly an interesting psycho-

[1] Macario, *Du sommeil des rêves*, 1857, p. 292.

logical phenomenon which may certainly be utilised from a therapeutic standpoint, but it is not the same thing which has been described in this chapter under the name of suggestion. In other cases there may be a beginning of true suggestion, mixed with the voluntary compliance of the subject who endeavours to play a part and to satisfy his physician. We should differentiate these complex cases, but we should not base upon them the description of a phenomenon. Whether the question is a moral phenomenon or a physical fact, one should always begin analysing the clearest cases. We consider the typical cases of *suggestion* to be *those complete and automatic developments of an idea which take place outside the will and personal perception of the subject.*

§ 3—SUBCONSCIOUS ACTS

By way of defining the term *suggestion*, we have said that it presented a principal psychological character, namely, its isolation from the other psychological phenomena,—its development outside personal perception. This characteristic has been established in all suggestions, but it shows itself in a still more evident manner in certain particular suggestions. The acts called forth by this process are so clearly isolated, separated from personality, that they deserve the name of *subconscious* acts. This study, moreover, very important in itself, if one would understand the accidents of hysteria, may also be considered a verification of the preceding analyses. Subconscious acts may be experimentally called forth under three different conditions: 1. when we provoke movements in *anæsthetic* limbs; 2, when we produce suggestions by means of *diversion of mind;* 3, when we make use of *post-hypnotic suggestion.* It will be sufficient to give briefly the description of these three phenomena before examining the common characteristics which are found in all varieties of subconscious acts.

1. *Movements in anæsthetic limbs.*—We have already described, under the name of *partial catalepsis*, movements and actions which were executed without the knowledge of the subject through anæsthetic members.[1] These acts seemed clearly related to sensations and thoughts, but the subject had not the consciousness, the personal perception of these ideas, nor the sensation of performing an action; these phenomena may be, therefore, considered as subconscious acts through anæsthesia. It suffices merely to recall their existence before passing on to the description of other actions of the same kind, but far more complex.

2. *Suggestions through diversion of mind.*[2]—The suggestions previously studied were directly made; that is, we faced the subject, we obliged him to look at us, to listen to us, to attend to our words. Certainly after some time the subject ceased to understand, ceased to account for the things he was told to do, and for his real condition, but at the beginning and for some moments he understood it all. The suggestions we are treating of now are made in a somewhat indirect manner, without the subject's having ever, even at the beginning, had a notion of what is suggested to him. We now step away from the subject and let him talk with another person or take up again the work in which he has been engaged. In watching him from a distance we soon notice that he has completely forgotten us and that he gives himself wholly up to his new occupation. It has been already observed, and repeatedly so, how hysterical persons fix quickly and completely their attention upon a new idea, forgetting all the others; it is a well-known consequence of the diminution of their field of consciousness. We now approach the subject and, while we avoid drawing

[1] *État mental des hystériques*, t. i.; *Les stigmates mentaux*, p. 186.

[2] See for a detailed study of these suggestions, "Les actes inconscients," *Revue philosophique* (1888, ii., p. 249), et *Autom. psychol.*, 1889, p. 237.

his attention upon us, speak to him and give him commands. It is well, especially at the beginning of such suggestions, to place oneself behind the subject and suggest to him in whispers very simple things which gradually may become more complicated as the case may direct. Such commands are performed without the subject's conversation being interrupted, or his having any perception of a suggestion, or being even aware of his obedience.

3. *Post-hypnotic suggestions.*—When a subject is in a somnambulic state of whatever sort, provided it be different from the one of the day before, we may give him a command, which is to be fulfilled later, at a moment when he is no longer in a somnambulic state, but has returned to his usual waking state; this is what may be called a post-hypnotic suggestion. It presents a very curious feature; namely, the subject, on awakening, has forgotten the somnambulic sleep and all the commands that were given him. How will such a suggestion, apparently forgotten, be then executed? It *is* assuredly executed, and at the given hour, with all the details indicated during the somnambulic state. Sometimes one subject, at the moment of performing the act, seems to fall back into a new somnambulic condition and to forget, as soon as accomplished, what he has just done; while others do the acts commanded them in a very particular and very interesting way. Lucy, Bertha, Isabella, and many others retain, after somnambulic sleep, the most natural appearance; they speak and act, well aware of all they do spontaneously; but, through all these natural actions they accomplish also, as if by absent-mindedness, the acts commanded them during their sleep. Not only do they forget these acts when done, but they are ignorant of them; they do not seem able to account for them, even when questioned at the moment they are doing them. All that relates to post-hypnotic suggestion seems to be no longer a part of their consciousness.

All these subconscious acts obtained through anæsthesia or mental diversion or as the result of a post-hypnotic suggestion are therefore all of the same kind; we can collect them in books and study their common characteristics.

The first characteristic to be noted in all these actions is that they are not simple, mechanical reflexes; they are *intelligent acts*, which can be understood only if we admit, as present in the mind of the subject, sensations, remembrances, and even complicated reflections. The simple cataleptic attitudes of the anæsthetic arm depended, as we have demonstrated, on the existence and persistence of certain very delicate muscular sensations; the adaptation of movements, however, to the nature of an object put into the hand, the obedience to verbal suggestions, cannot be understood if there are no tactile or auditive sensations. These movements manifest, likewise, remembrances. For example, we raise Isabella's anæsthetic arm, place it in a particular position, then lower it without her having noticed anything; a few moments later, by means of mental diversion, we suggest that she put her left arm in the same position with that of a moment ago; the arm is raised and held exactly as before. We can, as has already been seen, direct the anæsthetic hand of Margaret so as to make her write something; later, the hand will again pick up the pencil, and of her own accord she will write again the same word. Post-hypnotic suggestions, which are executed some considerable time after awakening from hypnotic sleep, could not take place if there was not in the mind of the subject a very exact remembrance of the commmand given during the somnambulic state.

The intelligent character of these subconscious acts becomes still more evident when, by some proceeding or other, we give the subject complicated suggestions which require, in order to be performed, reflection and even mathematical thought. Lucy, being in a somnambulic

state, we say to her, in a tone of suggestion: "When we strike our hands together twelve times, you shall go to sleep again." Then we speak to her of something else. She falls asleep, and, five or six minutes later, we awaken her completely. She had wholly forgotten what had passed during the hypnotic state, as also our private suggestion. Of this, an important thing here, we were assured: first, by the preceding sleep, which was real somnambulism with all its characteristic signs, according to all those who have studied these questions and verified the forgetting of similar suggestions; and finally, by the result of all the preceding experiments made on this subject, on whom we have always succeeded in proving this unconsciousness. Other persons surrounded Lucy and spoke to her about various things; yet, a few steps from her, we struck our hands together five times, at certain intervals, and rather feebly. Noticing then that the subject paid no attention to us and seemed in lively conversation, we drew near and said to her: "Did you hear what we have just now done?" "What? I paid no attention." "And that?" (we struck our hands together). "You have just now struck your hands together." "How many times?" "Once." We withdrew and continued striking less loudly from time to time. When we had thus struck six times, which, with the preceding six, made twelve, Lucy immediately stopped talking, shut her eyes, and fell back asleep.[1]

We have recopied this old observation, for it may be considered the type of a great number of experiments which we have described and which bring into evidence the existence of reflections and calculations even in subconscious acts. We will put aside these experiments and show only the most complicated act which includes them all—the suggestion of subconscious writing.

[1] "Les actes inconscients et le dédoublement de la personalité," *Revue philosophique*, 1886, ii., p. 584.

Let us take a case in which are united the most favourable conditions for the performance of subconscious acts. Margaret is anæsthetic on the right side and, when she does not look, does not at all see the movements of her right hand. It is very easy wholly to divert her mind, and when we make her talk with anyone or make her read aloud a few pages, she so forgets us that we can talk quite aloud when close to her without her noticing it; in short, it is easy to hypnotise her and to give her post-hypnotic suggestions, which will be executed in the form of subconscious acts. Well, we put a pencil in her right hand and, during her absence of mind, suggest that she write a few words. She executes the act in a subconscious manner, like all the others. But the automatic writing thus obtained will allow us to verify those sensations, remembrances, and reflections whose existence we had heretofore merely supposed. This writing will tell us the movements impressed upon the insensible arm; it will repeat under dictation the words which we pronounce and which the subject pretends not to hear; it will reply to our questions and reveal to us a thousand innermost thoughts which the subject would not confide to us or of which even she was completely ignorant. We shall see, later on, in treating of hemi-somnambulism, the enormous development which this writing may take. It is sufficient now to establish the intelligence it manifests. Subconscious acts possess, then, all the characteristics already recognised in suggestions; they are psychological phenomena, phenomena of intelligence.

If we pursue their analysis further, we shall see certain new features or at least the exaggeration of certain characteristics already presented in ordinary suggestions. The beginning of the direct suggestion was characterised, as has been seen, by a certain surprise on the part of the patient, by a certain resistance which could at times be prolonged for quite a while. The suggestions we have just

spoken of generally suppress completely all resistance. There are but a very small number of exceptions which are to be noted in regard to hemi-somnambulism. These acts are, as a rule, executed very rapidly, without hesitation; if we allowed Lucy to give attention to the execution of the suggested acts, she would struggle against the suggestion; she would advance a little, draw back again, and these hesitations would last quite a long time; we had then only to speak to her a little of something else and immediately her mind was absent and she executed unconsciously and very rapidly the suggested act.[1] Margaret will not tell us about the quarrel she has just had with her mother; she will resist a long time the most violent suggestions if they are direct ones, but she will immediately write what we ask her, if we do not insist, and allow her to become absorbed in something else. "Many authors," says M. Pitres, "have observed that suggestions through insinuation succeed often better than comparative suggestions."[2] They had probably employed, without being quite aware of it, suggestion through diversion of mind. As a result certain subjects who are a little or even not at all suggestible by ordinary means, are completely so when we employ these indirect methods. Renée will not obey any suggestions we make to her when she is before us; she is too watchful of herself, but when she is no longer with us and talks with other people, she executes at random movements we had tried to make her do in the morning. One of our former subjects, Léonie, does not present like other patients a real suggestibility in the waking state. If we speak to her directly and command a movement, she wonders, questions, and does not obey; but when she is speaking to other persons, we may succeed in whispering our command behind her, without attracting her attention. She then no longer hears us and tries no longer to resist; it

[1] *Autom. psychol.*, p. 426.

[2] Pitres, *op. cit.*, ii., p. 91.

is then that all suggestions are executed and that we may modify her mind as we wish. Permit us to recall, also, in this connection, the story of a very curious patient whom we studied this year with M. Charcot, whose remarks concerning delirium will appear later. Daill has fallen a prey to several demons; he sees them, hears them, he feels them speaking within him, they drive him to blasphemy, to run hither and thither, to tear himself, to kill himself. We tried, but in vain, to acquire some influence over his delirium; to suggest to him very simple movements and to hypnotise him. All was useless; not only does he not obey, but he laughs at us, heaps insults upon us. We then change tactics; we leave him to relate his misfortunes to others and to be as delirious as he chooses. When it appears that he has entirely forgotten us, we command, in a whisper, a few gestures which are executed perfectly without his knowledge; we cause him to act and even to write as we wish. We thus hypnotise him without his perceiving it, and succeed in changing and suppressing all his fixed ideas. It would really seem, if the metaphor be permissible, that the mind of such persons is a fortified town defended by a very feeble garrison. But if the guards are not numerous they are very agile, and they succeed in facing you by whatever side you wish to enter. Yet leave some adversary before the town to occupy the garrison and, soon forgotten, you may approach another side, and enter without striking a blow.

This absence of resistance, of personal will in subconscious acts is explained in a very simple way: the subject is ignorant of them. Absence of mind has produced, as is the rule with hysterical people, real anæsthesia. Maria's arm, or Justine's, which usually is sensitive, does not remain suspended when we raise it; but when the subject is absent-minded it remains and acts like an anæsthetic arm. While the subject talks with other persons he no

longer hears our words; he is for us systematically deaf. Léonie, while she talks, does not see that she holds her hands before her mouth, in the position of a flute-player; this is a systematic blindness. We asked Lucy one day to use all her efforts to resist us; she did not seem entirely to understand us, for she did not remember her obedience. She assured us, laughing, that she would certainly not execute the act we were about to enjoin. We give her a command during a moment's sleep and our command is executed immediately upon her waking; but she continues laughing, still saying: "Do try to command me to do something; you will see I shall not do it." In one word, they have in their consciousness not the least notion of these subconscious acts. Does not this new statement contradict the first? How can the same act be at the same time intelligent and unconscious? How can it contain sensations, remembrances, reflections when we admit on the other hand that the subject thinks absolutely nothing concerning this act? This apparent contradiction is not the result of a theory, it is the expression of facts; it would have to be admitted even if we could not explain it. But this remark is not new now; it belongs to a more general problem which has already been studied in regard to anæsthesia, amnesia, to all hysterical stigmata. We have been obliged to admit that there are two categories of psychological phenomena and two ways of understanding the word "consciousness": first, the elementary psychological phenomena T T′ T″ . . . (Figure 8) in the scale already studied, real phenomena, playing their psychological part, conscious perhaps within themselves in a very rudimentary fashion, but isolated from each other and the superior psychological phenomena; and, secondly, personal perception, P P, which consists essentially in synthesising these elementary facts and connecting them with the former notion of personality. This last

operation, this personal perception is reduced with the hysterical patient; he can no longer synthesise more than a few elementary facts: V V″, A A′, for instance. What is to become of these other facts, T T′ M . . . , which nevertheless exist ? It is incontestable that they remain often isolated, in a state of mental dust, without playing any important part. But the facts described before oblige us to admit that, in certain cases, these phenomena may also be grouped among themselves, and form in a P′ a partial synthesis more or less coherent, which will unite T′ M′ A″. This partial synthesis represents what we have described under the name of subconscious act.

Before drawing the conclusions of this study, we must

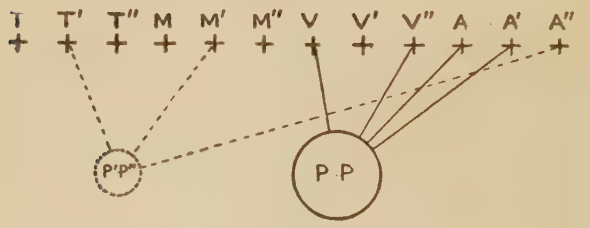

FIGURE 8.

point out a certain number of complex facts, the knowledge of which is indispensable to an understanding of suggestion and its effect on feeble minds. Up to this time we have studied only simple cases, in which the separation between conscious phenomena and subconscious phenomena was perfectly clear. It is, however, not always so; we may very often show actions and reciprocal reactions of these two groups of phenomena one over the other. Such a dependency seems at first sight hardly intelligible; how can these two phenomena, T′ and V, for example, depend one upon the other, associate one with the other, since we

have proved that they were isolated, that they belonged to two groups of different thoughts? It is because there is to be made here one more distinction: all the reunions, all the groupings of psychological phenomena, are not of the same order.

The automatic association of ideas is one thing, and the synthesis which forms the personal perception at each moment of life and the very idea of the Ego is another. The latter may be destroyed, while the former remains. This supposition, besides, agrees pretty well with all we have said about these two operations. The association of the ideas is the manifestation of an elementary synthesis which has already been effected, and which has connected, once for all, the phenomena with each other. Personal perception is the manifestation of an actual synthesis which, by a continued effort, repeated at every instant, brings back to the unity of the Ego all the phenomena which are produced, whatever be their origin. The patient may have become incapable of perceiving such or such auditive or tactile sensation, and yet by an old automatism which has not been destroyed, this non-perceived sensation may bring with it other images, visual images if you like, being a portion of those which the subject still perceives.[1]

If it is difficult to explain the matter psychologically, the fact is none the less indisputable. It presents itself in two different ways: at one time it is the conscious phenomena normally perceived by the subject, which bring along in their wake other subconscious phenomena, manifested solely by movements of which the subject is ignorant; at another time, on the contrary, it is subconscious phenomena, of whatever origin, which exist first, and which, from time to time, call forth in the conscious mind emotions, varied images springing up in an unexpected manner.

[1] *Autom. psychol.*, p. 234.

Let us examine a few instances of the first case. Certain hysterical patients cannot think of an action without executing it, but this execution takes place with some in a very singular manner; the subject is not conscious, and it takes place unknown to her. It seems that a part of the thought, the auditive or visual images which constituted it, have been perceived by the subject, but that the other part, the kinæsthetic and motor images, awakened by the first, remained subconscious. In this case, the patient is quite surprised to see the effects of her action conformable to her thought, certainly, but not to her will. Hence those expressions so often noted:

It is not I that walk ; it is my legs which walk quite alone. . . . When I think of some object, it seems as if someone took me by the hand to look for it; I go to it without knowing why; I ask myself who is this person. . . . He robs me of my thought, he writes what I think. . . .

Oftener, the subject does not substantiate these motor manifestations of his thought; he is ignorant of them and fancies that he simply thought for himself; it is the spectators who observe them and who use them to read the patient's thought unknown to him. It is this fact which plays the principal part of various processes of divination, the divining-rod, the explorating pendulum, cumberlandism, or the " willing game " of the English. Here is an example. We propose to Margaret that we guess, without her saying one word, the name she thinks most of. You may, with her, make use of various processes. For instance, we hold her right, anæsthetic hand, reciting softly the alphabet. She is to squeeze our hand violently when we pronounce the letters of the name in question; she is quite amazed at our guessing her thought. With Renée the subconscious movements are still more violent; she has convulsions of the whole body at the

moment when the letter or number of which she thinks is pronounced, and yet she does not understand any better how it is guessed. Processes of this sort are very numerous and have often been described; it is worth while to know them; they enable us often to strike the imagination of the patients and quickly to exert such power over them as leads to their cure.

Sometimes subconscious phenomena, joined to conscious thoughts, are more complex; if we put a pencil into Margaret's anæsthetic hand she writes the word she thinks of, yet she had no thought of writing it. There is here more than an execution; there is a development of her conscious thought. It is a real collaboration of the two groups of thoughts separated as to personal perception, but still very closely allied.

The dependency of these two groups of phenomena may be inverse and produce still more curious and grave effects. The subconscious phenomena which develop unknown to the subject may from time to time bring about certain psychological facts which will be perceived by the subject and will make irruption into his consciousness. This phenomenon may first be produced in a very simple way. The subject sees his own automatic movements; he reads his own subconscious writing, and thus takes cognisance of a fact, the origin of which lies outside of his consciousness.

The results of the act or simply the movements of the members have been seen by the subject. He has not felt the act within himself, for, as yet, he does not know what the question is, but he has perceived its outward manifestations as he might have perceived the act of a stranger. He then accepts this act or he suppresses it by energetic resistance. This is the case with many suggestions executed, so to say, with consciousness; the subject continues good-naturedly an act he has not begun himself; he even takes the responsibility thereof and invents reasons to explain it; but the act, for all this,

was not the less a subconscious phenomenon subject to the laws of psychological disaggregation.[1]

The subconscious act may influence consciousness even before its execution; it may call forth vague impulses which the patient calls "desires," the origin of which he does not understand. Lucy, to whom we gave a suggestion she is ignorant of, stops to say: "How funny that I should so *wish* to do this, and yet it is so stupid."[2] These subjects feel an act outlining itself and they interpret it as a vague feeling of desire.

Let us take a step further; subconscious ideas, before any kind of manifestation, may, through the association of images, create real hallucinations which will suddenly invade the consciousness.

While Léonie is not listening to us we whisper to her that the person she is talking to is wearing a most beautiful green coat. Léonie does not appear to have heard and goes on talking with this person; then, all at once, she interrupts herself and bursts out laughing: "Oh! dear me, how did you come to dress yourself in that way? and to think that I had not yet noticed it!" We whisper to her in the same way, telling her that she has a bonbon in her mouth; she appears likewise not to have heard us, and, if we question her, she does not know what we said, but yet here she comes to us making faces and crying: "Oh! who put that thing into my mouth?" The command had not been heard by the subject; the origin of the hallucination is unconscious; but the hallucination itself is conscious and all at once enters into the mind of the subject.[3]

We have already, while studying anæsthesia, seen many facts of this kind; we suggest to Bertha that she will see a butterfly when we touch her little finger. We touch the little finger of her anæsthetic hand and the

[1] *Autom. psychol.*, p. 425. [2] *Ibid.*, p. 427.
[3] *Ibid.*, pp. 242, 433.

touch is not felt; however, this subconscious sensation brings with it, by association, the visual hallucination of a butterfly, which hallucination is conscious. M. Binet pointed out analogous facts when he showed that an hysteric sees, under the form of visual images, impressions actually made on her anæsthetic hand.[1] Another test may also be connected with the latter; it has been described by English authors who have studied it especially under the name of "crystal vision."[2] If the subject looks attentively for some time on a moderately shiny surface, he sees appear on this surface images, phantoms; in a word, he experiences in a feeble degree visual hallucinations. These dreams, thus called up, are in close relation, as we have often demonstrated, with the subconscious thoughts of the subject; it is a thought, profoundly buried, which, for a moment, emerges to the light of consciousness. These minute experiments are not useless; they will serve to explain correctly natural phenomena. Very often the patients complain of an idea, an image, which suddenly invades their mind without their knowing why.

The extent of conscious reasoning [said M. Laurent, very justly, in a thesis both medical and psychological] is not very considerable with hysterics; unconsciousness with them will act to much better purpose than with the normal man, and ideas, the fruit of his reasoning, will emerge in greater number to the level of the consciousness. All authors have observed in hysterics alternations of sadness and gaiety, coming apparently without reason and being even inexplicable by an actual and flitting impression. This arises from the fact that, with them, reasoning, the association of ideas, unconscious memory, are constantly at work on excitations, whether consciously or unconsciously perceived, but which spring from

[1] Binet, *Revue philosophique*, 1889, i., p. 157.

[2] "Recent Experiments in Crystal-Vision," *Proceedings of the Society for Psychical Research*, 1889, p. 508.

conscious memory. . . . With the hysteric, as Dr. Bremaud told us, it is very difficult to reconstitute the sequel of a reasoning, the latter having for the most part taken place outside of consciousness.[1]

One may see by these rapid résumés what an important part these subconscious phenomena can play in the mind; they do not confine themselves to depriving the subject of a portion of his strength, producing considerable anæsthesias and amnesias; they mix themselves at each moment with the phenomena which had remained conscious. "It seems," as M. Myers said when speaking of certain phenomena of automatic writing, "that there are constantly messages sent from one layer of consciousness to the other."[2] These messages may at times be useful, and this continuous collaboration of the conscious and subconscious allows the hysteric to live and act without suffering too much from his anæsthesias and amnesias, namely, from all the lacunæ of his thought. But often, again, these unknown phenomena which invade consciousness may carry trouble therein and produce the gravest obsessions.

All these numerous phenomena which we have reviewed in this chapter are explained by a fundamental idea, namely, the development of certain psychological phenomena outside personal perception, outside personality. It was precisely to this same idea that the study of direct suggestions, analysed in the preceding paragraph, had brought us. Whether it interrupts the course of consciousness, whether it develops aside and outside of personal consciousness, suggestion has always the same character.

One word then can sum up these two studies: suggestion is always an idea *isolated* from the great mass

[1] L. Laurent, *Des états seconds, variations pathologiques du champ de la conscience*, 1892, p. 155.

[2] Myers, *Proc. Soc. Psy. Research*, 1889, p. 524.

of the other thoughts; it has an *independent* development. "The suggested idea or group of ideas," said M. Charcot, very justly, "find themselves in their isolation sheltered against the *control* of that great collection of personal ideas, a long time accumulated and organised, which constitute consciousness properly so called, the Ego."[1] "With certain subjects it is possible to call forth, by means of suggestion or intimation, a coherent group of associated ideas which *install themselves in the mind in the fashion of a parasite*, remain isolated from all the rest, and may be explained outwardly by corresponding motor phenomena."[2] We ask permission to preserve this striking metaphor: Suggestions, with their automatic and independent development, are real parasites in thought.

§ 4—THE CONDITIONS OF SUGGESTION

If suggestion is defined as set forth above, it is no longer a commonplace and constant phenomenon; it presents itself only in certain cases and under certain conditions, which it is necessary to determine. Suggestion appears to us to present two great characteristics: 1. It is a complete development; 2. It is a development independent of certain ideas. Both characteristics require certain conditions.

It is necessary, in the first place, in order for an idea to develop itself, that the innumerable images of which it is composed be awakened, and arrange themselves in a series in a proper manner. This is not an unimportant condition, though it is not always met. Certain minds no longer retain images of their sensations and, above all, they no longer keep up the systematisation of these images; they are incapable of calling them up and arranging them in a series; they are therefore not suggestible subjects. The type of such individuals will, from the first, come

[1] Charcot, *Mal. du système nerv.*, iii., p. 337.
[2] *Ibid.*, iii., p. 336.

under the name *dementia;* it is quite plain that with an insane person the images are no longer systematised, and that consequently the ideas are no longer either understood or developed. But, without going so far as dementia, numerous other patients are equally incapable of grouping so great a number of psychological phenomena around one centre, even when the question simply is to repeat an old grouping. We have studied, from this point of view, a certain number of deliriums, in typhoid fever, in advanced tuberculosis, in mania, etc. We have especially examined those minor states of raving which happen unexpectedly in a course of hysteria, in neurasthenia, or in the folly of doubt (*la folie du doute*). The patients are totally powerless to follow the same idea for even a few moments; they think by means of isolated images, or limit themselves to very simple images by consonance, by contiguity between a few neighbouring images. The ideas they are inspired with call forth only a few verbal images, a few dreams, a very few movements, and that is all. Incoherence is immediately established again. If we compare such a state of mind with that of an hysteric who for half an hour will develop the same dream, and around the same thought,—namely, that " of a journey to the moon,"—will accumulate thousands and thousands of images, the latter will be capable of preserving a suggested idea for entire months, and it will be seen that the insane are not all so suggestible as has been asserted.

The same fact may be still better verified if we consider the intermediary states of mind. Certain hysterics are but little suggestible, because they are *too ill*, and because their thought cannot for any length of time maintain the same orientation, were it even wholly automatic. We can give to some patients, Rose, Marie, or Margaret, a suggestion which will not be acted upon for three months; the remembrance will be preserved unknown to

them, and the act will be unconsciously performed. This experiment is absolutely impossible with Bertha; she develops admirably very simple and momentary suggestions, but she is incapable of giving to an idea so prolonged and so considerable a development. In an hour some attack or even the slightest emotion is likely to upset all,—"demolish" all, as she says,—and the suggestions which we may have made to her will have completely disappeared. Much hope has been cherished for the therapeutics of insanity through suggestion; we are afraid this operation could be applied only to very special cases.

Suggestion requires, in order to be developed, a mind relatively sane; this is an idea already expressed by M. Bernheim,[1] and we are happy to find ourselves agreeing with him. The first condition of suggestion is a certain strength of mind, and some patients are not suggestible because they are, so to say, below suggestion, like some infected patients who are incapable of having fever.

But should we immediately pass to the other extreme opinion and maintain that suggestibility is compatible with a mind normally healthy, and that it is continually met in the sanest persons? This is an opinion which appears to us equally unsound. Despite the affirmations of certain authors, we must confess that we have not succeeded in giving suggestions to people of normal good health. It is useless to discuss the sense of the word "health," and to pretend that ideal health does not exist. It were repeating the sophism of the Greeks regarding the bald-headed man. We speak of men generally considered normal, without pathological or hereditary antecedents or personal blemishes in a neuropathic sense, without actual defects medically appreciable. If we take a person of that kind—a kind that is numerous, we must confess—and if we state to her that there is a

[1] Bernheim, *Hypnotisme, suggestion*, 1891, p. 224.

little dog at the corner of the table where she is sitting, she will laugh in our face and experience no hallucination whatsoever. This fact appears to us incontestable, and to speak of suggestion with sane persons one is obliged to consider quite different facts—effects of education, habits, recollections, beliefs, etc. They are psychological phenomena which are apparently akin to suggestion, but the mechanism of which is very different. These facts have only gradually become automatic, thanks to the patient's consent. These acts, even to-day, are accepted by the individual who is aware of them, and assimilates them with his personality. The result is that such actions are not aggressive; they are limited in their development by other thoughts with which they are brought into relation. Docile, obedient persons, disposed to think of others as having more intelligence and experience than themselves, who on account of this easily believe what they are taught, are not suggestible persons. This complete and automatic development of an isolated idea of the personality, in the fashion of a parasite, is not met with in the normal man.

On the other hand, every time that we have established in a person unmistakable suggestibility, we have had no difficulty in demonstrating numerous and evident traces of mental disease, more or less grave, such as excessive absence of mind, or even properly called anæsthesias, doubts, fixed ideas, phobias, all the manifestations of abulia. We find in the past of such persons all sorts of neuropathic accidents, and the simple fact that suggestibility is still persistent nowadays should impose great reserve on the physician in regard to prognosticating their future. Suggestibility with them should, in fact, not be considered a simple exaggeration of docility and normal belief. Such persons are oftener neither docile nor believing; they have an unsteady, undisciplined disposition; they themselves recognise that they do not

succeed in "believing." "I have no more confidence in anybody; I have no confidence at all in you," they often say to me; and yet you can make them see through hallucination all you wish. They are incapable of voluntary obedience, which demands strength of mind, and they undergo in a sickly sort of way all automatic impulsions.

This analogy between suggestibility and the diseases of the mind may be verified on the hystericals themselves. It is easy to see that they are not always suggestible to the same degree. Often, we know, they are not suggestible because they have another idea in mind; nothing is so difficult as to induce suggestion in a person who has already received a suggestion or who has a fixed idea. But we do not speak of this. Certain hystericals left to themselves in a way, who certainly have no fixed ideas, become gradually less and less suggestible. What is the reason? Simply that they are getting well. We have observed it a number of times and under very particular circumstances. One hysterical, Lucy, had attacks every day; did not eat, did not sleep; she was suggestible in the highest degree. We obtain control over her; she becomes calm, the attacks cease, she eats and sleeps, becomes stronger, recovers her remembrances, and next her sensibility; and we can no longer give her any more commands. She obeyed us, be it understood, with docility and voluntary consent; but she had no longer this automatic development of ideas without personal consciousness and recollection. All this had disappeared.

Furthermore, it is known that during the very course of the malady, under all sorts of influences, the hystericals change much in their psychological state. After an attack, after a prolonged sleep, whether natural or artificial, after any kind of emotion, or during certain abnormal states either called forth artificially or happening spontaneously, the patients find themselves momentarily

transformed. The thick veil which prevented them from understanding things is rent asunder and they have lucid intervals, as Marcelle once told us. Now, during these lucid intervals, there will be observed two simultaneous things: suggestibility has considerably decreased or has even disappeared; no more automatic and impersonal acts, no more hallucinations in contradiction of real sensations.[1]

It is also found that anæsthesia has disappeared, that the subject is no longer either absent-minded, or anæsthetic, or abulic. The observations on complete somnambulisms which have already been published are very significant in this respect; they show us the simultaneous disappearance of both suggestion and the stigmata of hysteria. The same relation may be verified inversely; suggestion attains its abnormal power only at the moment when the enfeebling of the mind becomes manifest. I have often seen hystericals resist the suggestions made to them at one moment and execute them nevertheless a few hours later, during a crisis or a period of illness when the enfeebled mind became incapable of resisting the development of a foreign idea. We command Renée, for example, to put out her tongue; she resists and the suggestion does not take, as is said; two days later we find that during an attack she has constantly put out her tongue, a thing she never did before. Lucy, who had ceased being suggestible, came to see us again eight months later, complaining of megrims, insomnia, nightmares; she was again absent-minded, anæsthetic, amnesic; but a word sufficed to render her as susceptible to suggestions as we could wish. Another hysterical, Marie, almost entirely cured except during a few days of her menstrual period, and at that time just three days,

[1] M. Pitres has also remarked that all subjects are not equally suggestible in the different hypnotic sleeps (*Leçons sur l'hystérie*, 1891, ii., p. 166).

again exhibited all the stigmata of psychological disaggregation.

This weakness, which accompanies suggestion and which varies with it, may be analysed in certain definite cases. We establish at that moment in the subject all the psychological blemishes which we have already described: anæsthesias of the hysterical type, or equivalent conditions of absence of mind; amnesias, doubts, all the troubles of the will and attention. We see that the patient has lost the power of synthesising at that moment a certain number of psychological phenomena; that he has consciousness of only a few facts at a time, that the range of his personal consciousness has become very contracted.

This contraction not only modifies the sensibility and memory—it disturbs likewise all the acts and all the thoughts. The patients are no longer able to combine several thoughts, to maintain equilibration between antagonistic ideas, to pass easily from one idea to another. Bertha becomes absorbed in one idea and can no longer think of anything else; she gives herself up entirely to this single thought, which apparently assumes extraordinary proportions. When she thinks of the Salpêtrière she pretends having been there all her life and forgets the streets of Paris. When she thinks of the streets of Paris, she knows no longer the Salpêtrière and loses her way in it. Marie becomes so possessed with an idea that she is not susceptible to any outward impression; you may lift her up, carry her from one room into another, without her being aware of it. The patients themselves anticipate this condition. "I am too much absorbed in my ideas," says Margaret; "I am about to be ill again." "It is not my fault if I am violent," said Célestine, crying after having committed some foolish thing. "I did not remember that you had forbidden it; . . . I have not many ideas, you know; I cannot think of so

many things. . . . I do everything that comes into my mind." Bertha one day stood in contemplation of some buttons a lady had at her waist, and set about to pull them off. When she was stopped, she looked quite stupefied and unhappy: "Oh! what was I about! . . . a trifle, you see, attracts my attention, and I forget everything else." There may be cited here a word of this same patient, which we have already quoted: "I fall into an idea as into a precipice and find it very hard to reascend."

These are very clear alterations of thought as they exist in suggestible individuals. Not only do these psychological characteristics accompany suggestion, but it seems to us that they explain it too. Why is it that in our normal state former ideas, called up by some means or other, do not develop completely? It is because we are conscious of them; because we connect them from their beginning with the enormous mass of other recollections, of other images, which constitute our personality. They have their place; they play their part in the great system, but they are not isolated and independent, and their development is restrained by the development of all the other thoughts.

"To arrest one thought," said M. Ch. Richet, "there must be another to impede it; to hinder a sentiment another sentiment must arrest its advance."[1] Certainly; but in order that these phenomena may be in opposition to each other, it is not enough that they be simultaneous, they must also be united in the same consciousness. This is precisely what is wanted in suggestible persons. They are not able to bring together so many thoughts into one and the same personal perception, and consequently cannot set them in opposition to each other. "By reason of the easy dissociation of mental unity," said M. Charcot, in other words, "certain centres may be put into play

[1] Ch. Richet, *L'homme et l'intelligence*, 1884, p. 529.

without the other regions of the psychic organ being made aware of it and called upon to take part in the *processus*." [1]

It is enough to observe how a suggestion is being followed to see that things really take place in this way. When you present to any one of these patients a whimsical idea in contradiction of the reality, she is surprised; she appears to receive some shock, and she resists for a time; this means that for some time she retains in her consciousness the notion of her personality, the knowledge of the real outward objects; and these correct ideas are opposed to the contradictory thought which our words awaken in her mind. Then, as Margaret said, when we questioned her on her impressions, her own attention tiring very quickly, the patient is not able to retain so many things in her mind at once: "Let my attention," she says, "be but turned away a moment and I am gone; I know nothing more; I am absorbed in what you tell me." Let us translate this speech and say her too-narrow consciousness no longer contains the antagonistic recollections and sensations presented to her; she forgets that she is at the hospital, that she is twenty-three years old, etc., and all the elements contained in the suggested idea develop freely.

M. Max Dessoir [2] remarks that this disappearance of the antagonistic images is but a result of the suggestion; it is because it begins to develop that it causes all other ideas to disappear. This is correct: in some cases suggestion, while developing, invades the whole mind and suppresses, as has been said, every other idea. But this development has from the beginning been made possible by the lack of resistance in the antagonistic thoughts. At the moment of suggestion there is a shock, an emotion

[1] Charcot, *Mal. du syst. nerv.*, iii., p. 455.

[2] Max Dessoir, "Experimentelle Pathopsychologie," *Vierteljahreschrift f. wissenschaftliche Philosophie*, 1890, p. 198.

tion, which destroys the feeble personal synthesis of the subject. The suggested idea remains isolated, more or less completely separated from the other ideas; it can then develop and suppress all else, even foreign thoughts.

At the beginning of this study on the conditions of suggestion, we have admitted that suggestion could not develop in sickly minds—that it demanded, in order to attain to its full power, minds relatively sane. We have just now demonstrated that it depended on a lack of synthesis, on a weakening of consciousness. Are not these two affirmations contradictory? Not at all. A symptom may disappear in certain maladies and still remain a pathological symptom. The crepitant râle does not exist in all stages of pneumonia; it disappears in many serious lung affections; it is none the less a very characteristic sign of the disease. The same with suggestion: it does not belong to all mental disorders, but is the sign of a particular mental disease. It is necessary for its occurrence that the automatic association of the psychological elements be preserved and that the actual synthesis of the phenomena be altered or reduced. It requires as its essential condition a malady of the personality.

This malady of the personality, which is the condition of suggestion, may be met with in many circumstances. It is found in certain infectious states,—in typhoid fever, in tuberculosis, in intoxications, especially in alcoholism. We described formerly a very remarkable case of suggestibility in a man during his convalescence from an attack of delirium tremens.[1] This alteration of personal perception has been demonstrated in many nervous maladies; in neurotics, in St. Vitus's Dance, with doubters, with idiots even; it is momentarily produced by great emotions, violent moral shocks. But, however incontestable these observations may be, they show us nearly always

[1] "Actes inconscients," *Revue philosophique*, 1888, i., p. 251.

an incomplete suggestibility. It must be confessed that there is a particular disease which unites in a wonderful manner the two essential conditions of suggestion: the preservation of automatism and the diminution of personal synthesis; this is the hysterical state. The study of all the stigmata has constantly shown us these two characteristics in hysteria. We must not, therefore, be surprised if the mind of hystericals is, pre-eminently, the ground favourable to suggestion and that we have demonstrated in it the extraordinary development of this phenomenon. A tendency to suggestion and subconscious acts is the sign of mental disease, but it is, above all, the sign of hysteria.

CHAPTER II

FIXED IDEAS

THE study of suggestion has shown us that the thoughts of hystericals are not equilibrated; that under diverse influences one of them may develop to an extreme extent and live, so to say, isolated, its own life, to the great detriment of the mental organism. This tendency is not only manifested in artificial experiments; it continually gives place to natural phenomena, which are quite analogous to suggestions. Fixed ideas are for us phenomena of this kind; that is to say, psychological phenomena which are developed in the mind in an automatic manner, outside the will and the personal perception of the patient, but which, instead of being, like suggestions, experimentally called forth, are formed naturally under the influence of accidental causes. This difference in the artificial or natural provocation of automatic phenomena has, from a clinical and especially therapeutic point of view, quite grave consequences to justify this distinction. Ideas of this kind have been described at length in the case of patients considered as lunatics. They went under the name of obsessions, impulsions, phobias; they characterise the delirium which develops with some neurasthenics or, as they are often called in France, certain degenerates. We shall repeat here what we have already said in speaking of abulias.[1]

[1] *Stigmates mentaux de l'hystérie*, p. 122.

Unquestionably, this characteristic belongs to these patients; we in nowise deny it; we shall only say that it also belongs to hystericals; that with them it is very frequent, and that it is the cause of the great majority of their accidents. After having reviewed the different forms which the fixed idea takes with hystericals perhaps we may be able to prove certain characteristics peculiar to these patients and differentiating these phenomena from other forms of obsession met with among divers lunatics.

§ 1—DESCRIPTION OF FIXED IDEAS AMONG HYSTERICALS

A lunatic tormented with fixed ideas, whether he accords them full credence or struggles against the encroaching delirium, has always an exact knowledge of the thoughts which torment him. He expresses them by words, or, if he does not explain them clearly, it is because he seeks to conceal them; if he meant to be sincere he could always express them. It is quite different with the hystericals: it is rare with them to account clearly for a fixed idea which besets them. Generally, they maintain that their mind is perfectly tranquil, without any preoccupation. It is not always possible to accuse them of dissimulation and their sincerity may be tested. It is sometimes found that these patients are very confiding and very sincere, and that they even confess most hidden things. Is it to be supposed that they could conceal a fixed idea much more insignificant? A large number of authors have not thought so; they have remarked that hysterical accidents do not seem connected with the patient's thoughts. These accidents continued to exist even when the patient was quite absent in mind and appeared to think of something else. It has even been demonstrated that these accidents persisted during the night, during a profound sleep, or during attacks; in conditions, in a word, when the subject did not seem capable

of thinking of his fixed idea. These quite correct observations have led to the denial of fixed ideas in hysteria.

We think that it is necessary to admit the existence of a particular form of fixed ideas peculiar to hystericals, which we would designate as *subconcious fixed ideas.* The word " consciousness," when applied to fixed ideas and deliriums, has sometimes taken, in the language of alienists, a particular meaning. It means that the subject is aware of his delirium,—recognises its being false. An unconscious delirium is, on the contrary, a delirium to which the patient abandons himself without judging it, and which he accepts as true. We are sorry that we cannot accept this meaning, in reality incorrect, of the word "consciousness," for we have been obliged to use these terms in another sense. A fixed idea, like any kind of psychological phenomena whatever, is conscious, not when it is judged, but simply when it is known by the subject, and it is in this sense that the fixed ideas of those under so-called obsession may be said to be conscious. We believe that it is extremely important, in order to understand hystericals, to know that with them fixed ideas may lose this character and present themselves under the aspect of subconscious phenomena.

How can the existence of an idea, the definition of which is not known to the patient and cannot be expressed, be clearly demonstrated ? We must have recourse to all the processes of observation which the experiments on subconscious acts have brought to our knowledge. Subconscious phenomena are manifested, as we have seen, in various ways : it will be the same for subconscious fixed ideas. 1st. These ideas may develop completely during attacks of hysteria and express themselves then by acts and words. 2nd. In dreams more or less agitated which take place during sleep and natural somnambulisms and which often happen unexpectedly ; it is at such moments that fixed ideas are wholly confessed. 3rd. One of

the best processes consists in causing the patient to enter artificially into a state similar to the preceding ones—namely, an imposed somnambulism. At one time, abandoned to himself in this artificial condition, he has dreams which he expresses aloud; he gives himself up to acts as in a natural somnambulism, and reveals his thoughts; at another time he talks to us, answers our questions. It is astonishing to see how subjects during their somnambulism find again with precision and clearness recollections, ideas, of which they had no consciousness during their waking state. They explain then most accurately the idea that besets them and give a detailed account of all the sensations, of all the images which have determined and still determine the accidents. 4th. It is known that subconscious thoughts may be manifested even during the waking hours of the patients and without their knowing it. Certain acts which they perform automatically when they are vacant in mind enable us to guess these ideas. But when it is possible to employ it, the process, which consists in utilising automatic writing, is more exact than all the others. It is useless to go back to the description of this writing discovered by the spiritualists; if it has to-day no longer the religious character the disciples of Allan Kardec assigned to it, it may in many circumstances subserve a medical purpose. Let us also point out a process, less known, which, in very particular cases, may also serve to bring to light subconscious ideas: the process of "crystal gazing," described especially by English authors. Many patients, hystericals almost always, we think, cannot look fixedly upon a moderately shiny surface without having indubitable hallucinations. They see their own dreams filing off in the mirror, and sometimes they thus happen to perceive and express ideas they could not account for previously. Such are the processes, still very imperfect, which permit us to penetrate a little deeper into the minds

of patients. Allow us to reproduce, as an example, an old observation which we have already published, and which, although lacking precision on certain points, is interesting, for it seems to us, saving possible error, one of the first observations made concerning subconscious fixed ideas in a hysterical:

It would be necessary to pass in review the whole of mental pathology and perhaps even a large portion of physical pathology, to show all the psychological and corporeal disorders which a persistent thought may thus produce outside of personal consciousness. . . .

One of the subjects we have often cited under the name of Marie presents an equally curious disease and cure. This young girl was brought from the country to the Havre hospital because she was thought insane and her cure despaired of. . . . On the approach of menstruation, Marie's disposition changed; she became sombre and violent, which was not habitual to her; she complained of pains and nervous shocks in all her limbs. Yet matters went on as well as usual during the first day. Twenty hours later, however, the flow stopped suddenly and a severe chill shook her whole body. A sharp pain started slowly from her abdomen to her throat and the great hysterical crisis began. The convulsions, although very violent, did not last long and did not look like epileptoid movements, but they were followed by one of the longest and severest deliriums. At one time she would utter cries of terror, talking all the while of blood and fire, and trying to escape the flames; at another again she played like a child, talked to her mother, climbed on the furniture, upsetting everything in the room. This delirium and these convulsions alternated with short moments of respite during forty-eight hours. The scene ended with several blood vomitings, after which there was a return to the usual condition. Marie calmed down, but did not remember anything that happened. In the interval of these great menstrual crises she suffered from small contractures, sometimes in the arms, or in the chest, or in the intercostal muscles, from varied and very changeable

anæsthesia, and above all from a complete and continual blindness of the left eye. Besides that, she had from time to time slight attacks which were without much delirium, but which were characterised by manifestations of terror. This illness, so evidently connected with her menstrual periods, seemed wholly physical, and afforded little interest to the psychologist. For this reason we at first paid but little attention to the case; we had but a few experiments with her in hypnotism, and a few studies as to her anæsthesia, and we avoided all that might have disturbed her about the time when the great crises occurred. She remained thus seven months at the hospital, the various medications and hydrotherapeutics which were tried doing nothing toward any modification of her case. Besides, the therapeutic measures, particularly the suggestions relative to menstrual periods, had only bad effects and increased the delirium.

Towards the end of the eighth month, she complained of her sad fate and said in a kind of despairing tone that she saw very well that there was no help for her. "Come now," we said to her, impelled largely by curiosity, "explain to us for once what you feel when you are about to menstruate?" "Why, you know it very well: everything stops; I have a big chill, and I don't know any more what happens to me next."

We then asked for correct information as to the manner in which her first menstruation had begun, and how it was interrupted. She did not at once answer clearly; she seemed to have forgotten a great part of the history of it. We then concluded to put her into a deep somnambulic sleep which might possibly restore those recollections. We were not mistaken. We brought back the exact remembrance of an event which had never been fully known.

She had menstruated the first time when she was thirteen years old; but, in consequence of some childish fancy or some talk overheard and not well understood, she took it into her head that there was some shame connected with the affair, and sought some means whereby to stop the flow as soon as possible. In the course of some twenty hours, she went out secretly and plunged into a big tub of cold water. She

succeeded completely; the courses stopped suddenly, and notwithstanding the severe chill which followed, she was able to reach home. She was ill for a considerable time and in delirium for several days. However, all calmed down, but the courses did not reappear for five years. When finally they did, they brought with them the troubles I have described. Now, if we compare the sudden stoppage, the chill, the pains she describes at the present day in her waking state, and the story she tells in her somnambulic state, we come to the following conclusion: Every month the scene of the cold bath is repeated, brings about the same stoppage of the menses, and a delirium which, to tell the truth, is far more severe than formerly, until a vicarious hæmorrhage takes place through the stomach. But she is not normally conscious of anything of this and does not even understand that the chill is the consequence of the hallucination of the cold bath; it is therefore likely that this scene takes place below the surface of consciousness, and is the hidden cause of all the troubles in the case.

We do not care to show how, by modifying this subconscious, fixed idea, we have been able, quite easily, to cause the attacks and the delirium to disappear; they are questions of therapeutics foreign to our present study; but we must recall to mind that all the other symptoms presented by this patient were of the same nature as the preceding.

After having established this result, it was necessary to study the other conditions. We pass over the details of the psychological research, which was sometimes difficult: we found the crises of terror were the repetition of an emotion she had experienced in seeing, when she was sixteen, an old woman killed by falling down a stairway; the blood of which she always spoke in her crises was a recollection of that scene; the same in regard to the image of the fire: it probably occurred through an association of ideas, for it is not connected with anything exactly definite. By the same process as the one mentioned above, bringing, namely, by suggestion, the subject back to the time of the accident, we succeeded, though not without trouble, in changing the image—in showing to the

patient that the old woman had simply stumbled and was not killed, and in erasing the terrifying conviction. The crisis of terror returned no more.

Finally, we wished to study the blindness of the left eye; but Marie when awake objected, saying that she was so since her birth. It was easy to verify the matter by means of somnambulism, and tell her she was mistaken. By the well-known process we change her into a little child five years old; she resumes the sensitiveness she had at that age, and it becomes manifest that she could see very well then through both her eyes. It is then at six that the blindness began. On what occasion? Marie, when awake, persists in saying that she does not know. During the somnambulic sleep, and thanks to successive transformations during which we make her rehearse the principal scenes of her life, we discover that the blindness began at a certain moment and as the result of a trifling incident. She had been obliged, despite her cries, to sleep with a child of her age who had *the mumps on the whole left side of her face.* Marie had subsequently patches of mumps which seemed somewhat identical with the child's, and were seen at the *same place.* These patches reappeared for several years at the same time, then were cured, but we failed to notice that from that time she *was anæsthetic on the left side of her face and blind in the left eye.* This anæsthesia did not leave her from that time, at least not to go beyond what has been observed at some time previous to that to which we transport her through suggestion; she has still that same anæsthesia, although the rest of her body recovers at certain epochs complete sensibility. Her cure was due to the same attempt previously made: we carried her back to the child she had such a horror of; we made her believe that the child was very nice, that it had no mumps at all. She was not quite convinced at first, but after two repetitions of the same scene, we gained our point: she caressed the imaginary child without fear. The sensibility of the left side returned without difficulty, and when we awakened Marie she saw quite plainly with her left eye.[1]

[1] *Autom. psychol.*, 1889, p. 439.

A little later, in our description of Marcelle, an interesting patient, presenting above all abulia and fixed ideas, we noticed that her fixed ideas presented themselves in two different ways. Now they were clear and complete, expressed during certain attacks by hallucinations and words which we had called crises of obscuration, and during artificial somnambulisms which put the patient into the same kind of state; sometimes these ideas were vague, solely expressed by automatic movements for which the patient could not account, or by doubts which tormented her mind on waking, during the lucid intervals which succeeded the attacks.[1] The ideas no longer existed in the second period except in a subconscious state.

Finally, in our last study of continued amnesia, we have shown that these troubles of the memory depended often upon the persistency of the fixed ideas in the mind of the patients;

these ideas were sometimes noticed and confessed by the subject himself, who complained of continued obsession; sometimes they were not clearly expressed by the subject, but manifested themselves by movements or significant attitudes; often, again, they were very hard to discover, the patient not seeming to have any recollection of them nor even a clear consciousness, and it was necessary to make use of all sorts of psychological processes to guess this permanent dream which prevented the patient from understanding and synthesising sensations and images. Madame D. was an exact realisation of this third case; when questioned on this point, she pretended that she was not troubled by any idea whatsoever, nor by any dreams; that, with the exception of lack of memory, her mind was as free as in the past. The thing might have been true, and this continued amnesia might have been a primitive fact. Yet the foregoing examples, so like Madame D.'s case, assured me that fixed ideas, even unconscious, could

[1] "Étude sur un cas d'aboulie et d'idées fixes," *Revue philosophique*, 1891, i., p. 280.

play some part or other and that they invited research. We were able to observe certain significant facts: 1st. Madame D. had at times—rarely, it is true—slight attacks of hysteria. During these attacks she manifested great terror and repeated constantly words like the following: "My husband, my poor children! . . . that poor Jane who has no mourning gown . . . Oh! that man, that miserable man! . . . etc." 2nd. At night, this patient behaved in two very different ways; sometimes, and it was the fact that had been observed in the first instance, although it occurred very seldom, she fell into a sleep quite profound; a calm sleep; and then dreamt of the incidents of the day: "The Salpêtrière . . . M. Charcot . . . the physicians in white aprons. . . ." But generally she did not sleep at all and for the following reason: as soon as she began to lose herself — doze for but an instant — she would wake with a start, all in a tremble and in a terrible fright. She could not tell what had frightened her, and looked all round as if she had some vague idea that someone had just entered. This terror would return every time she began to doze again, so much so that she preferred keeping her eyes open and would rather not sleep. The other patients, her neighbours, thought her asleep, and were not aware of anything wrong. Once, while in a profound somnambulism, she explained to me these nocturnal terrors: the moment she was asleep, she had an hallucination; she saw entering the room the man who had scared her in the month of August and heard him say distinctly these words: "Prepare a bed, Madame D.; your husband is being brought home dead." 3rd. Even during the somnambulism, she had, when left some time to herself without being spoken to, sudden starts of terror. She would stretch her head as if listening to someone, and murmur a few words between her teeth: "Oh! this man, this miserable fellow! . . . I would rather die, I shall kill myself . . . etc." It was no easy thing to bring her out of this state of revery when she had once been allowed to sink too far into it, for then she would become insensible, which was not usual with her. 4th. Even during her waking hours, she had frequently sudden starts, gave smothered cries which she imme-

diately repressed, because, she said, she did not know what they meant. In one word, the preceding remarks make us often think that the terrifying event of the 28th of August has not disappeared from Madame D.'s mind; it is repeated in the form of hallucinations much oftener than we think; it possesses her mind during the day and destroys her sleep in the night.[1]

In studying separately the various accidents of hysteria, we shall often have occasion to adduce other examples of subconscious fixed ideas; we must point out here only the most characteristic cases to give a comprehensive idea of the general characteristics of the phenomenon. One of the observations which appear to us worth briefly recalling here is that of a patient whom we have often alluded to by the name of Isabella. She arrived at the Salpêtrière in an extremely weak condition, for she had been refusing to eat anything for six weeks. The injected food was never thrown up and was perfectly digested; it seemed evidently a case of purely mental anorexia. However, neither exhortations, nor begging, nor threats have been of any avail; the patient tries to eat, but at the sight of the first mouthful she pushes all the rest away with loathing. Of course, it will be said, this is a fixed idea; unfortunately it seems impossible to discover the cause of it. Isabella has been questioned on all sides by many people and in all sorts of ways; she does not appear to be a dissembler, and when she is urged she confesses to much graver things, things she would have every reason to conceal, but she has no explanation for her refusing to eat. "I assure you," she said, "I am not at all possessed with the idea of not eating; it seems to me even that I should like to eat; but at the moment of beginning, the thought of it chokes me, disgusts me, and I cannot. Why? I don't know; I assure you it is not that I wish to die; I begin even to be

[1] "Amnésie continue," *Revue générale des sciences*, 1893, p. 176.

afraid that I may; but despite all my efforts to eat there is something that prevents me." If we stop at this we shall let her die of hunger indeed, not understanding her case. This must not be. We examine her in all her subconscious states: in her sleep, during the delirium of the attack, in her somnambulism, her automatic writing, etc.; but we always get the same answer. Her mother, who is dead, appears to her during the attacks, blames her for some fault she has committed, tells her that she is not worthy to live and that she ought to join her in heaven, and bids her for this reason not to eat. This hallucination is connected with a whole succession of anterior events and it is evident that it does not alone constitute the whole of the disease. But at least it keeps under its mastery the symptom of the anorexia, for it is enough to modify it for the symptom to disappear. The patient when awake is quite surprised to find herself eating easily without feeling "that something which prevented her before." True, after the next attack the anorexia begins again, because the hallucination has again taken place and persisted under the form of subconscious suggestion. It is for this subconscious delirium that she will have to be treated.

Isabella presents constantly conditions which have the same character; we shall cite but one other in the interest of the study of dementia. For a week or so she has been gloomy and sad; she hides and will not speak to anyone. We have trouble in getting a few words from her, and these she says very low, casting her eyes down: "I am not worthy to speak with other people. . . . I am very much ashamed, I have a crushing load on my mind like a terrible gnawing remorse. . . ." —"A remorse about what?"—"Ah! that's just it. I am trying to find it out day and night. What is it that I could have done last week? for before I was not thus. Tell me candidly, did I do something very bad last

week?" This time, as will be seen, the question is no longer about an act, but about a feeling, a general emotional state which she interprets as remorse; she is equally incapable of understanding and expressing the fixed idea which determines this feeling. If you divert the subject's attention, you can obtain the automatic writing, and you will see that the hand of the patient constantly writes the same name, that of Isabella's sister, who died a short time ago. During the attacks and the somnambulic sleep, we establish a very complicated dream in which this poor young girl thinks she murdered her sister. That is quite a common delirium, you will say; perhaps so; but for a hysteric it presents itself in a rather curious manner. She suffers only from its rebound, experiences only the emotional side of it; of the delirium itself she is wholly ignorant; the latter remains subconscious. There are many other phenomena exhibited by this young girl which it were well to describe; we shall come upon them again in the treatment of hysterical deliriums; quite a number of other examples will gradually confirm this first description. We are glad to find that several authors, particularly MM. Breuer and Freund, have recently verified our interpretation, already somewhat old, of subconscious fixed ideas with hystericals.[1]

It will be seen by this last example that, in some cases, a small portion of the fixed idea may be conscious. Isabella feels that she is troubled by some remorse, she knows not what. It thus frequently happens that hystericals, during their normal waking time, complain of a certain mental trouble, so much so that they partly look as if obsessed. Célestine experiences thus feelings of anger which she cannot explain. Bertha has sudden hal-

[1] Josef Breuer and Sigm. Freund in Wien, "Ueber den psychischen Mechanismus hysterischer Phänomene," *Neurologisches Centralblatt*, E. Mendel, 1893, Nos. 1 and 2, extract p. 6.

lucinations " which," she says, " come upon me I know not whence." All at once she sees her uncle or her cousin before her, of whom she had no thought a moment before. Catherine hears an inner voice constantly saying to her: " I am consumptive; I shall no longer be able to walk; all is over," etc. These apparent phenomena constitute but a small part of the fixed idea. In reality these patients have complete dreams, connected, in the case of one, with an insult; in the case of another with misfortunes brought upon her family by an uncle; in the case of Catherine, with a consumptive aunt whom she nursed at night. These dreams are subconscious and manifest themselves clearly only by the foregoing processes; they send " messages " to the normal consciousness and disturb it. At times the fixed ideas seem to fill the whole consciousness, but that happens only in abnormal states of somnambulism, or attacks separate from the normal consciousness. These characteristics of the fixed idea are clear and frequent enough to characterise hystericals. We shall meet them again in most of their attacks.

§ 2—DYSÆSTHESIAS AND HYPERÆSTHESIAS

Among the many conditions in hysteria the simplest are disorders of sensation. We do not mean by this those diminutions of sensation which have already been studied under the name of anæsthesia, but more accidental disorders, and for the patient more inconvenient. They are mostly alterations or exaggerations of the normal sensibility: dysæsthesias and hyperæsthesias. Many hystericals seem to have imperfect perceptions of the impressions which strike their senses. This is sometimes simply the consequence of anæsthesia; they say, for example, that their food has no taste, that it tastes like sand, and they call for vinegar and very spicy condiments. But the transformation is often more complete

and the patient reveals a perception different from that which a normal man would experience under the same conditions. One pretends that everything smells of ether, another complains that her soup tastes of poison, although she would have some difficulty in explaining the taste. One patient delights in red, and the dullest red; she sees "bright rays that penetrate and warm her very heart." A remark of this kind has started the theory which attributes to all hystericals a passion for red. It is far from being a general thing; for Bertha, quite to the contrary, finds red "a colour so repugnant that she says it might give one nausea." Certain contacts give to hystericals quite abnormal sensations, and it is partly because of this notion that formerly special studies were made on the influence of magnets and metals. Léonie took pleasure in touching the south pole of magnets, "the good side," but she had a horror of the north pole, which contractured her; she liked to feel gold and handled jewellery with evident satisfaction; this contact excited her extremely. One of M. Gilles de la Tourette's patients experienced a sense of burning when she touched gold, and her skin really showed the marks of it.[1] M. Pitres has carefully described a phenomenon of the same kind which he calls "haphalgésie" (ἅφη, contact, ἄλγος, pain): "It is," he says, "a variety of paresthesia characterised by an intensely painful sensation in consequence of the simplest application to the skin of certain substances which, upon one in a normal condition, would have but the slightest effect.[2] Perhaps in certain special cases we must bring in some electric or chemical phenomenon to explain such facts; but in the great majority of instances the question is of the simplest. M. Briquet had already explained some of these facts with much common sense: "However queer these appe-

[1] Gilles de la Tourette, *Traité de l'hystérie*, p. 165.

[2] Pitres, *Leçons sur l'hystérie*, i., p. 65.

tites may appear," he says, "we discover quite frequently their *raison d'être*. Thus, a young woman who was particularly fond of the embers of her chafing-pan, told me that she had long ago been particularly fond of bread; from that she passed on to toasted bread, then to crust burnt to a cinder, and next to small coal itself. I suppose that if we sought the origin of many of these strange tastes, we should find it as simple as this one."[1] We have very often followed this advice and can appreciate its value. It is all too evident that the smell of ether, the taste of poison, stand in some relation with the preoccupations of the patients. If Bertha finds the red colour so repugnant, it is because it is the colour of blood and recalls to her the tragic death of her father. Léonie experiences queer sensations from the contact of the magnet, because all the magnetisers who have studied her made use of the magnet and put into her head the most fanciful theories about magnetism. These notions have become absolutely fixed in her mind and ineradicable, and even to-day, thirty years after the death of the magnetiser, they have still all their effect. All Léonie's symptoms may be cured by applying alternately the two poles of the magnet on the sore spot. It would be extremely difficult to cure them in any other way. Will it require much imagination to understand why all subjects take pleasure in handling gold-pieces? These explanations may appear somewhat commonplace, but we should not always despise simple explanations.

Psychological explanations of this kind, which have often been indicated under the name of theory of expectant attention or theory of autosuggestion, have been much criticised. It has been observed that very often the subject does not expect anything, does not reason, and yet experiences the emotion without his being told as soon as the magnet or the metal is applied to his arm.

[1] Briquet, *Hystérie*, p. 254.

It may be answered that the question here is not of reasoning, of voluntary attention, but of an automatic association of ideas with subjects extraordinarily predisposed to this kind of phenomena.

M. Morton Prince, in a very curious work, insisted upon these " associations neuroses," in which an association of ideas corresponding probably to an association of nervous phenomena, brings with it automatically the thought and even the sensation of a pain in consequence of such or such a determined sensation.[1]

It has also been objected that the emotion even took place when the object is applied on the anæsthetic side of the subject and that, consequently, there could then be no question of psychological phenomena. It is known that for us hysterical anæsthesia does not suppress sensibility and that there exist a large number of subconscious suggestions (*à point de repère*). Finally, several authors pretend that experiments have been made in which the subject could in nowise distinguish the nature of the object applied to his arm, and that, as a regular thing, the reaction never failed to appear. A non-magnetic bar had not the same effects as a magnetic one; a copper-plate had not the same effects as a plate of gold. These experiments are, to my mind, extremely difficult ones; one would have to be alone with the subject and in a laboratory especially fitted up for the purpose. Unless a great many precautions be taken, the attitudes, the involuntary gestures of the bystanders and of the operator, the smaller details of the apparatus become, to the mind of the subject, signs (*points de repère*) which bring about the phenomena automatically. We must not forget that cutaneous sensation even, and especially upon anæsthetic members, may be very delicate. If, without

[1] Morton Prince, " Association Neuroses: A Study of the Pathology of Hysterical Joint Affections, Neurasthenia, and Allied Forms of Neuromimesis," *Journal of Nervous and Mental Diseases*, May, 1891, p. 6.

her noticing it, we slightly touch Léonie's left hand, she will see a bouquet before her; if another person touches that hand, she will not see anything. The difference of the contact is very slight, and yet it is always appreciable. Why should not the subject feel in the same way such or such side of a magnetic bar to which he is accustomed and which presents known irregularities? Why should he not distinguish an iron magnet from one of wood? Still more, we think that without being an hysterical, one can by the mere contact distinguish between metals; their surface and especially their apparent temperature, which depends on their degree of conductivity, are not identical. Why should this discrimination not take place also in the mind of the patient? All these difficulties should be known and taken account of in the experiments.

When experiments are made in this way, it often happens that phenomena which seemed surprising disappear. When we made experiments with the electro-magnet, even upon the most sensitive subjects, we saw that the subject no longer discerned either the poles or the magnetisation. M. Charles Richet, who made these experiments with great care, has come to the same conclusions. The English Society for Psychical Research has instituted a special committee, the Reichenbach committee, and has had very delicate instruments constructed, without being able to establish this sensibility. What are we to conclude from it? This: that we should not deny the existence of certain dysæsthesias of physical origin, and that there remain studies to be made on the part to be played by electricity, magnets, and metals; but in these studies, serious attention should be paid to psychological phenomena, for the dysæthesias, by far the more numerous and incontestable, are due to phenomena of association of automatic ideas.

Among the dysæsthesias, there is one which appears to

raise a few interesting problems and deserves to be studied separately; it is a visual disorder designated by the name of *monocular diplopia*. Some patients—not many, we think—complain of a particlar trouble with their vision; they see double. Generally, this diplopia is binocular and naturally results from a defect of convergence of the optical axes, whatever be the cause. But sometimes the observer makes this singular discovery, namely, that this diplopia persists even when one eye of the patient is closed, that the diplopia may be monocular. The fact is strange enough to have attracted attention, and many were the interpretations offered. These theories may be ranged in two categories, physical theories and psychical theories. We mean by this simply that for some there occurs in the eye an alteration which ends in the formation of two images on the retina; if one could see the images painted on the retina, it would be found that there are really two: for others, the optical phenomena that take place in the eye remain normal, and there is but one single image of the object painted on the retina; it is a cerebral alteration, then, which causes the subject to believe in the existence of two images, in doubling the objects by a sort of elementary visual hallucination. Skokalski, 1840, Dugniolle, Guépin, Découdé, Gat, and Fick, 1856, and especially M. Parinaud, have collected all the arguments favourable to the first interpretation. In regard to M. Parinaud he considers the matter in the light of a spasm of the accommodative muscle which contracts unequally the diverse segments of the crystalline humour and determines the formation of several distinct images of the same object on the retina.[1]

This author insists on a very important detail, the proof of which he demonstrated to us on a patient, Justine, whom we take as an example of monocular diplopia.

[1] Parinaud, "De la polyopie monoculaire dans l'hystérie et les affections du système nerveux," *Annales d'oculistique*, mai–juin, 1878.

This symptom is evidently accompanied by a disorder in the accommodation; the patient is exactly accommodative only on a point situated at a determined distance from the eye; if a little too much one way or another, she has more or less trouble in discerning objects. Now diplopia seems intimately related with the spasm of accommodation, since it disappears when the object is placed directly on the point by which the eye is accommodated and really exists only when the object is brought forward or moved back. Better still, if by appropriate glasses this accommodation is modified, the diplopia disappears even when the object remains placed at a distance where before it was seen double. M. Parinaud seems to have shown us one of the conditions of the phenomenon, a disordêr of the accommodation. Is this condition the only one ?

Several authors, Fallot, Galezowski, 1865, Adams, Ord, 1881, Fontan, 1885, have explained the fact by a cerebral disorder, which they describe in a more or less precise manner. At last M. Brunschvig, of Havre, seems to us to have given the question a very important impetus by placing himself resolutely on the psychological ground, demonstrating through divers experiments that the physical mechanism of the eye cannot explain all the details of monocular diplopia.[1] We are going to repeat on the patient, Justine, some of the experiments of M. Brunschvig, adding a few new details:

The left eye being closed, a stick of red wax is placed straight before the right eye; it is seen double; the distance which separates the two images is of about five centimetres and the two sticks are seen quite parallel. We move off some four metres, holding the stick vertically, and it is still seen double; whatever the distance there is the same spacing between the two images.

[1] Brunschvig, "La diplopie monoculaire," *La Normandie medicale*, 15 août, 1889, p. 285.

Justine changes a little the spacing of the images if one moves away; it is difficult to verify it, for she sees very badly and very confusedly distant objects. But we have noticed another detail in regard to the same fact: the distance which she allows to the two images is very variable, not as to space, but as to the nature of the objects which are shown her. If we show her a match placed at one metre's distance, she declares she sees two, separated by three or four centimetres; if we tell her to look at our head similarly placed, she replies that we have two heads, entirely separated one from the other; that means that she separates two points—the two noses—by thirty centimetres at least.

We then place the stick horizontally and transversely before the eye, and at this moment the images are superposed with the same spacing between, as in the preceding experiment. We incline it then to forty-five degrees before the eye and gradually until it becomes horizontal to the prolongation of the visual axis, and in all these positions it is seen double with superposed images.

This experiment is interesting, for there is no optical apparatus capable of undoubling an object always the same way, always having the extremities of the images absolutely superposed in all the positions. We reproduced it with Justine in the following manner: we drew upon a paper a straight line, *ab*, and as she saw two lines, we requested her to follow these lines with a pencil. One of the lines traced by the pencil coincided with mine, the second, *a'b'*, was parallel to mine and superposed (Fig. 9). We should add that one of our friends, M. Mergier, has shown us drawings obtained in the same manner from another patient who presented monocular diplopia and in which the parallelism of the images became modified according to the inclination given to the primitive line (Fig. 10). We have never observed a similar case ourselves.

M. Brunschvig adds a last experiment, which he justly considers demonstrative. The patient with monocular diplopia of the right eye looks into the box of Flees with both eyes open; she claims to see three wafers, two to the right and one to the left; now the one which is to the right and which she sees double is precisely the one which the left eye can alone see. This experiment cannot be repeated with Justine, for she has monocular

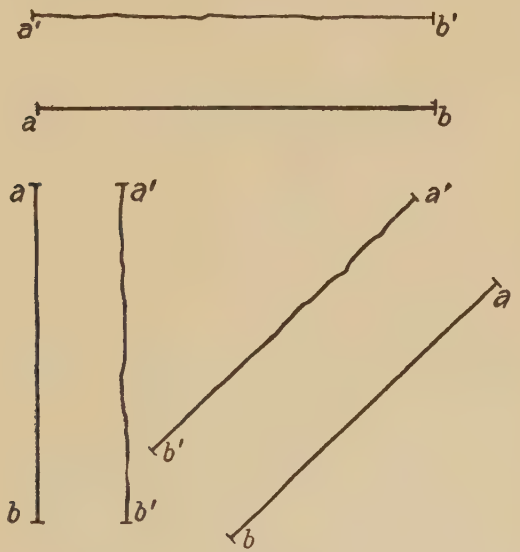

FIG. 9

diplopia for each eye, considered by itself; when she looks into the box she sees four wafers. We shall add only a detail to show how great a part a psychological interpretation plays in diplopia. When she looks at a head and sees it double, she also hears two voices and pretends that they are different, one from the other.

We must recognise, we think, after the preceding experiments, that, in certain cases at least, monocular diplopia, in the sense we have indicated, is not a purely physical fact. The trouble of accommodation, studied

by M. Parinaud, is the point of departure of an illusion; the patient in reality sees the objects, which are not exactly at the point to which her eye is accommodated, confusedly, and not doubly. It is through habitual hallucination, through a fixed idea, that true diplopia is produced. It is probable that this phenomenon of diplopia may be produced in various ways; besides the diplopia of physical origin, of which M. Parinaud speaks, there is room for supposing a psychical diplopia.

But whence comes so strange a fixed idea? In the observation of M. Brunschvig, the origin of diplopia was very clear and very simple. The patient had strabismus.

At the beginning of her strabismus, her two eyes being open, there occurred several times double images. Now, as it was the right eye that was strabismic, Z. needed no longer

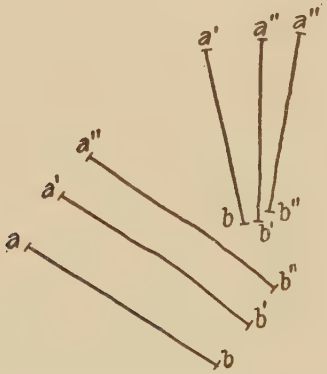

FIG. 10

to declare it diplopia in her. This idea once well fixed in her mind, as soon as they wished to test it, it was enough to make her look at an object with her right eye alone, and she saw it single immediately.

This explanation unfortunately cannot be applied to our patient, who did not squint. But there is with Justine another fact extremely interesting for the moral theory

of hysteria, which is to play here a similar rôle. She noticed, herself, that she could not look with both eyes simultaneously.

I very well know [she said] that I look either with one eye or with the other, but never with the two together; there is one eye which does not work and which is even painful. I can, however, change, and then it will be the other eye that will not look and be troublesome to me.

M. Parinaud showed us an ingenious experiment, which allows us to verify what she said. While she reads a book, a pencil placed vertically before her two open eyes prevents her from reading certain letters; this would not happen if she could see with both eyes. When she tries to look with both eyes she sees double, and it is then a binocular diplopia in conformity with known laws. This binocular diplopia is with her the result of a defect of convergence and of a blending of the images, so often pointed out by M. Parinaud as commonly found with hystericals. Usually this binocular diplopia does not trouble her, for, thanks to a process now well known, she stops perceiving the image of the eye which does not look; it becomes an abstraction and she has no personal perception of it. It is possible that some patients begin thus with a defect of binocular vision and end with neglecting the perceptions of one eye, thus producing the unilateral amaurosis. But here, the patient can still see with each eye separately. Must we connect this defect of binocular vision with the disorders of attention so marked in this patient? Must we recall that she is incapable of perceiving two sensations, even two tactile sensations, at once? At any rate, it is probable that this binocular diplopia, resulting from a defect in the convergence of the eyes and in the mechanism of attention, has been with her the point of departure for that fixed idea which causes her to see two images with a single eye as

soon as the vision becomes a little confused. Certain cases of monocular diplopia seem to us to be connected thus with the disorders of attention and the automatism of fixed ideas.

Among the disorders of sensation those that form the most important accidents are the hyperæsthesias, or rather hyperalgesias. Certain parts of the body seem endowed with so delicate a sensibility that they are constantly painful and become the starting point of sharp pains and other accidents as soon as they are subjected to the least contact. These phenomena seem to us as yet imperfectly known. M. Briquet wished to place them in the first rank with the stigmata. It appears to us that most hyperæsthesias, at least those which we have been able to study and understand, are closely connected with fixed ideas, and it is for this reason that we have described them as accidents of hysteria. These exaltations of sensation have been classified in various ways; we may, as does M. Briquet, distinguish them according to the organs affected and describe dermalgias, myalgias, myosalgias, arthralgias, cephalalgias, nephralgias, cystalgias, hysteralgias, cœlialgias, thoracalgias, pleuralgias, etc.[1] We may also reproduce the classification which has often rendered us service and distinguish systematic localised and generalised hyperæsthesias. These distinctions may be useful from certain points of view; but as we wish, above all, to bring out the general character of hyperæsthesias of psychical origin, we purpose, first of all, to separate the true hyperæsthesias from the false hyperæsthesias.

Hyperæsthesias deserve to be called true when a veritable exaggeration in the delicacy, in the acuity of one sense is established. Many authors have described marvellous things attributed to hysterical, sensory acuities, giving the illusion of transparency. We believe that these hyperæsthesias are much rarer than is supposed,

[1] Briquet, *op. cit.*, pp. 229–263.

and that a certain perspicacity of the subject, reflexions more or less conscious, joined to very ordinary senses, make these pretended marvels generally very comprehensible. We do not, however, doubt certain exaltations of the senses which have been observed either during waking hours or more frequently during somnambulism. Not having had the opportunity to observe on this point very characteristic facts, we shall simply repeat the opinion already expressed by the old magnetisers, and which seems to us very plausible. Hystericals are able to withdraw their attention very easily; in the same way as they can neglect and completely forget certain sensations, they can concentrate all their power of thought upon certain others. Our senses may be put into action by very slight impressions—impressions which we ordinarily neglect to perceive. It has been maintained, and not without reason, that subconscious sensations are much finer than our conscious perceptions. It is these ordinarily subconscious phenomena which penetrate into the personal perception, when our attention is strongly excited.[1] It is probably phenomena of this kind which, by association of ideas, awaken the reveries and divinations of lucid somnambulists. Léonie is not able, when requested, to distinguish our hand from those of others by a slight and momentary contact. Yet this distinction is very well realised, without her knowing it, when we touch her anæsthetic hand, and is accompanied with several very characteristic automatic phenomena. The psychological study of the true hyperæsthesia, when it shall be based on very clear cases, will lead to the discovery of interesting characteristics of unconscious sensation, and will give precision to our knowledge of the power of attention.

Certain hyperalgesias may also be considered true, namely, by the pains hystericals often feel in the head.

[1] H. Oppenheim, *Thatsächliches und hypothetisches über das wesen der hysterie*, October, 1889, p. 5.

We do not mean superficial sensations, exaggerated sensibility on certain parts of the scalp, but a pain of a cerebral nature which is not connected with any fixed idea, and which a number of patients, of a very different character, have, it seems to us, regularly experienced under the same circumstances. We referred to this pain recently, in describing the cure of the amnesia (a most complete one) of Madame D.

> The return of remembrances, the operation, whatever it was, by which the personality recovered possession of these so long-forgotten remembrances, was accompanied with violent pains in the head. We have known Madame D. to scream with pain, to experience a vertigo during which she could not stand, and even to talk deliriously when she re-entered into possession of an important group of remembrances. These symptoms were reduced, and even disappeared, when once the remembrances became distinct." [1]

This phenomenon is frequent with hystericals. We have tested it at the beginning of severe attacks; at the awakening from deep somnambulism, or again at the moment of a passage from one somnambulic state to another. It takes place especially among hystericals tormented with fixed ideas, and especially when we try to modify these fixed ideas. The patients express this pain by saying that they have a stone in the head, or water in the head, and often there results a delirium from this pain. Marcelle complained of having an animal in her head that gnawed at her brain; and we were surprised lately to hear Maria, who has never had any intercouse with the first patient, employing exactly the same expressions. It is useless to say that we are absolutely ignorant of the physiological cause which gives rise to such a pain.

The hyperæsthesias which most interest the physician

[1] "L'amnésie continue," *Revue générale des sciences*, 1893, p. 178.

when he studies the accidents of hysteria are the false hyperæsthesias, or those which result from fixed ideas. Over various points of the body there is developed, apparently, an extreme sensitiveness. The slightest touch produces great pain, provokes cries, spasms, and even attacks. These points may be met with over almost the whole surface of the body, over all the organs, even the nose, as we have seen it once, or over the mucous membrane of the nostrils, as M. Gilles de la Tourette has described it.[1] These painful zones, however, have often their seat mostly on particular points—on the genital organs, the testicles, or ovaries; over the abdomen, over the articulations, the knee, or particularly the hip. The ovary, the abdominal hyperæsthesias, the arthralgias, the hysterical coxalgias, the knee of Brodie, etc., are well-known manifestations of neuroses. We do not care to write the history of these researches, nor undertake the medical description of these symptoms; they are found very completely treated in the works of M. Pitres[2] and M. Gilles de la Tourette.[3] We limit ourselves to the study of the psychological phenomena which accompany or which call forth abnormal sensitiveness.

A few remarks seem to justify our denomination of false hyperæsthesia which we have applied to this fact, to distinguish it from the pains which accompany important lesions and cases of veritable hyperacuity of the senses. It is a well-known fact that these pains, apparently so violent, are usually not accompanied with organic alterations. "Absence of redness and tumefaction," says M. Pitres; "few spontaneous pains or none at all; no sensitiveness to touch at the heel; no muscular retractions nor vicious attitudes. What organic lesion could persist for nearly two years with this ensemble of negative

[1] Gilles de la Tourette, *op. cit.*, p. 303.
[2] Pitres, *op. cit.*, i., pp. 181, 188.
[3] Gilles de la Tourette, *op. cit.*, p. 222.

symptoms ?" [1] Nor are they accompanied with a particular delicacy of sensation. H. seems afraid as soon as we want to touch her arm; she follows with terror our approaching finger; she jumps and utters frightful screams if we but graze her skin. We thought at first that we might study in this case tactile hyperæsthesia, and meant accurately to measure this astonishingly delicate sensitiveness. After having quieted the patient, having promised her a hundred times that we would not press very hard, we made her look away and applied the æsthesiometer on her arm. We were surprised at first to find that the patient cried the same at contact of whatever kind, and did not seem to suffer differently when we pressed hard or slightly. In the second place, she distinguished very imperfectly the distance between the two points of the instrument and did not recognise the objects put on her skin. As M. Féré said, after having made similar observations: "It is but an exaggeration of sensibility to pain; the simple contact is felt less than it is on the sound side." [2] Is there even a real exaggeration of sensibility to pain ? This sensibility is very confused, since all impressions call forth the same pain without variations. With another patient we discovered in this respect a still more decided fact: she howled as soon as she *saw* our hand approach her abdomen; but when we made her look away and talked to her of something else, she did not even notice that we were pinching strongly the skin of the abdomen or were pressing on it. Her abdomen, so hyperæsthetic in appearance, was, in reality, anæsthetic. M. Brodie had already observed, in respect to hysterical coxalgia, that the pain is stronger when the patient "watches the examination she is undergoing [3]; if, on the contrary, something takes her mind

[1] Gilles de la Tourette, *op. cit.*, p. 222.

[2] Féré, *Arch. de neurologie*, 1882, i., p. 285.

[3] D'après Gilles de la Tourette, *op. cit.*, p. 236.

from it, she scarcely utters a complaint." Let us add that we have also verified in this respect a former observation of M. Briquet.[1] This hyperæsthesia is not constant, and several patients, H. and M., for instance, when they are in a state of somnambulism, lose this abnormal sensitiveness. In one word, this variable and contradictory hyperæsthesia is, in reality, not accompanied with any serious modification of the sensitiveness. The tactile sense and even the sense of pain remained normal in this part of the body; this is what we wished to express in calling this phenomenon a false hyperæsthesia.

Wherein, then, does the phenomenon consist? It seems to be evidently connected with psychological phenomena. Often, in fact, hyperæsthesia is systematic; Estelle, Dr. Despine's patient, utters cries as soon as a strange person wants to touch her; but she does not suffer when she is handled by her mother or her habitual douche-attendant.[2]

There are many somnambulists who will not allow anyone to touch them except their hypnotists, and suffer when any other persons come near them. Many subjects who cannot be touched on any of their sensitive zones without having an attack, can touch them themselves without inconvenience.[3] We will add that the slightest touch may provoke great phenomena when it is done experimentally, and that there occur constantly during the day accidental touches caused by clothing or other things without the patient's uttering the least complaint. When these hyperæsthesias are localised, they have no anatomic repartition, but rather a functional one; "they superpose themselves upon the function," understood in a coarse, popular way, like the anæsthesias whose psychological nature we have admitted for these very reasons.

This supposition will be verified if we consider, besides,

[1] Briquet, *op. cit.*, p. 656.
[2] Despine d'Aix, *op. cit.*, p. 24.
[3] Pitres, *op. cit.*, p. 47.

the monotonous regularity of these hyperæsthesias which for years persist in remaining exactly the same. The contact of such or such a spot brings with it always such or such pain, such or such gesture, such or such attitude of the subject. Organic maladies do not thus remain unchangeable; on the contrary, the duration and the regularity of psychological automatism are sufficiently known. Dr. Perrier's processes, in 1865, to put Léonie to sleep or awaken her, to contracture her, or put her into a cataleptic state, have still the same success to-day. A somnambulist well trained preserves indefinitely the same moral habits. We have the right to compare these phenomena of suggestion with the hysterical hyperæsthesias, because we know exactly that suggestion has the greatest influence on this phenomenon. "At first," said M. Séglas, in speaking of a patient of this kind, "a touch of any sort provoked attacks; now, there is required for that, the touch of determinate zones. . . . Besides, even in pressing on the latter, if at the same time care is taken to make appropriate suggestion to the patient, the attack does not take place."[1] Zones may be modified by various processes—by the magnet, passes, insufflation, etc., which we may be permitted to consider as psychical processes.

It is not impossible to go further and to determine which is the intervening psychological phenomenon. It is sufficient to examine the initial accident and to compare the phenomena which now occur, when we touch the affected zone, with those of the beginning. There is nearly always a very unmistakable accident that determines real suffering at the beginning of these hyperæsthesias, which seem to prolong indefinitely a momentary pain. We can mention only a few examples, for the facts are extremely numerous. Sometimes a real illness causes a

[1] Séglas, "Des dangers de l'hypnotisme," *Société medico-physiologique, 29 octobre, 1888.*

local pain, which becomes the starting point of a hysterical hyperæsthesia. M. Guinon reports numerous examples of surgical lesions, tumours, etc., becoming the seat of hysterical points[1]; he shows in a curious observation that a syphilitic and hysterical individual presents a cephalalgia which for many reasons may be connected with hysteria and which yet seems to copy the characteristics of a former syphilitic cephalalgia.[2] M. Rost, whose case we noted in the service of M. Hanot, is a man who to-day is evidently affected with hysteria, but he complains mostly of painful pricks in the right thigh; the first of these pricks is located in the middle of the buttock, the other in the region of the trochanter, the third a little lower in the same direction. These, it would seem, are certainly the points of sciatica; it is probable, however, that it has nothing in common with it. The limb is not powerless; the sudden extension of the knee is not painful; the pain, when we press on these points, has very clear characteristics; it does not vary, whatever the degree of pressure, and it brings with it severe attacks of hysteria. They are hysterical points, but they develop in a place where existed the pains of a real sciatica, which the patient had last year. Oftener still, the original pain was caused by an accident. In some observations of Gilles de la Tourette, a hyperæsthesia of the face had for its starting point the pain of a decayed tooth.[3] The hyperæsthetic points of a limb were, by accident, tied too tight with a rope.[4] Among the patients whom we observed, Dec. was bitten by a dog in the right calf, where there is a hyperæsthetic and hysterogenic point. Herb. fell on the abdomen; result, hyperæsthesia of the abdominal wall. Smi . . . was thrown against a lamp-post; result, enormous hyperæsthesia in the abdominal

[1] Georges Guinon, *Les agents provocateurs de l'hystérie*, 1889, p. 180.
[2] *Ibid.*, *op. cit.*, p. 298.
[3] Gilles de la Tourette, *op. cit.*, p. 275.
[4] *Ibid.*, *op. cit.*, p. 247.

region; two years after the accident he still wears on his stomach a big layer of cotton to protect him against accidental touches; when you speak to him, he scarcely listens, for he is all the while preoccupied watching his interlocutor's hands for fear they might come near his stomach. The remembrance, the image of a past pain, seems to be associated with a particular sensation and reproduces itself as soon as this signal is given. It will be objected that it is not always thus, and that many hyperæsthetic points have their place in regions free from all former pain or any traumatism. Certainly, there are points the formation of which it is difficult to explain in this or that particular case; but, if we are not mistaken, these hyperæsthetic points will easily find their place in one or the other of the following categories. We must not forget that many hystericals succeed in gradually localising their ailments, at first quite vague, either through imitation of other patients or after medical investigations. On the other hand, certain organs are naturally sensitive and become very easily the starting point of pains, as the stomach, the testicles, the ovaries. These latter organs are almost always painful during pregnancy; they are frequently so during the menstrual period; is it unlikely that one of these pains, more or less transitory, may have struck the mind of the patient as a serious accident? Let us add, moreover, as M. Charcot formerly observed,[1] that there is often in hysteria a congestion, a turgescence of many vascular organs, which may increase the sensitiveness of the ovary. We have many a time noticed this fact on the thyroid body; many hysterical people have a goitre, which increases during emotions and attacks, and the surface of which is particularly sensitive. Finally, we should not forget how very frequent among hystericals are the associations of ideas and of even the strangest of sensations. MM. Breuer and Freud, who,

[1] Charcot, *Mal. du syst. nerv.*, i., p. 329.

like ourselves, have established the character of fixed ideas in hysterical phenomena, observe that the slightest pain occurring unexpectedly during a meal may become the starting point of a tenacious gastralgia, that "the connection between the provocation and the symptom may be symbolical; a moral pain may engender neuralgia, a moral disgust start vomiting."[1] These authors cite, as example, the observation of a very intelligent man who was present at the operation performed on the anchylosed hip of his brother. At the moment when the articulation cracked he felt a violent pain in his own hip, a pain which has continued since last year. We may quote, in the same sense, the following observation which we obtained through a patient in M. Charcot's service. Faidh. complains of pain in her legs, and we discover an intense cutaneous hyperæsthesia on the inner surface of the thighs. This hyperæsthesia was grafted on an unquestionable hysterical state, but appeared difficult to explain by itself. Questioning the patient and examining her, we discovered with surprise that she was a virgin, though married for three years. It was not difficult to obtain a confession from her when awake. The patient had always looked upon her husband with horror and could never tolerate his approaches. This moral horror took the form of a hyperæsthesia in the region of the adductors, the *custodes*. The hyperæsthesias which do not clearly depend on a former condition will always find their place in one of the preceding categories and may then be considered as particular forms of fixed ideas.

Not only may we establish here the fixed idea at the beginning of the malady, but we may be able to show sometimes that it still exists in the mind of the subject, although she may not always be able to account for it. We shall cite only two cases, for they require a detailed presentation to be understood.

[1] Breuer et Freud, *op. cit.*, p. 3.

COLINM. (observation made in M. Hanot's service). Colinm. was a fireman on a locomotive, when he became the victim of a serious railway accident; picked up under the ruins, it was found that he was seriously wounded in the abdomen. He remained six months at the hospital and was cured. He presented no nervous accidents and had recovered completely. Six years later he experienced violent and terrible emotions; he saw his wife die in her bed by his side from cerebral hemorrhage, and a short time after he lost a child from diphtheria. Morbidly sad, and vaguely suffering, he at last came to the hospital to be cared for, for he was threatened with some disease in the abdomen. The abdomen was, in fact, extremely tympanitic, and the seat of intense hyperæsthesia.

Now, we do not hesitate to say that this abdominal hyperæsthesia, which showed itself six years after the railway accident, was due to the persistently fixed idea of that accident. Col. . . was very well during these six years, but he was obliged to give up former habits of intemperance because of a singular fact. Formerly, when he allowed himself to be carried away by friends into more than proper jollity, he was quite happy. After his accident he noticed that he could not get drunk. He would become sorrowful; intoxication terrified him; he talked ever of a locomotive rushing upon him, and "every time he indulged in too much drink he suffered severely from his wound, which was, however, well cicatrised." To-day, if you press on that scar, you provoke an attack of hysteria. In this attack he will not for a moment think of his later troubles; he can talk only of the railway; he opens terrified eyes in seeing the train rush upon him, and falls backwards as if crushed. This man suffers consciously from his actual troubles, but this state of depression has permitted the development of a fixed idea dating six years back, which then appeared only in times of intoxication.

MARIA, whom we have observed for the last three years, has never presented hysterical symptoms in the region of the abdomen; has not even any ovary. She is nevertheless attacked by a grave metritis complicated by a slight salpingitis. Some few months ago we took this patient to M. Térillon for a gynæcologic examination. M. Térillon was kind enough not only to examine her very carefully, but also to give us a few explanations touching the symptoms we had observed. He told us about the lumps which were felt in touching her, of their slight importance, and he declared that this patient had no need of being operated upon. Some time after, Maria came to tell us that she suffered horribly in her abdomen and she wished to know whether she were with child. In fact, her abdomen was surprisingly tympanitic and showed on the lower part an area of hyperæsthesia. She could not account for the accident since she spoke of pregnancy, and yet, as soon as she was in the somnambulic state, she gave us the explanation of the phenomenon: "It is the tumour M. Térillon spoke of." The fixed idea, completely subconscious, absolutely unknown to the patient when awake, was thus one of the most easy to establish and modify.

We have gradually penetrated the psychological nature of these hysterical hyperæsthesias; they are not exaggerations of tactile sensations, nor even of the sensation of pain provoked by contact; they are false hyperæsthesias, solely due to ideas awakened through association in respect to this contact. As soon as the subject *knows* that the skin of the affected place has been touched, whether he learns it by sight or knows it by a normal tactile sensation, he experiences not a pain, properly so-called and localised, but a general emotion, an anguish, a frightful terror. These emotions bring with them trouble in the respiratory organs, movements of defence, spasms, and even complete attacks. Finally, the subject has often,

at the same moment, his mind invaded by hallucinations more or less clear, by painful or terrifying remembrances.

All this ensemble of psychological phenomena is regularly reproduced on the occasion of contact with a certain region of the body. The sensation is of itself painful, not by its intensity, but by its quality, its characteristics; it has become the signal with which are connected, by associations of ideas, an ensemble of extremely painful phenomena, the reproduction of which the patient justly dreads. They are, as we have said, hyperæsthesias due to fixed ideas.

§ 3—TICS, AND THE MOVEMENTS OF CHOREA

The troubles of motion, which occur accidentally with hysterical patients, are innumerable, and we do not pretend to name them all; we wish only to show by the study of some observations the important part fixed ideas may play in these conditions. We shall begin with examining a few involuntary movements, in which conscious or subconscious thought is most evident.

Many hystericals, while apparently remaining in their normal state, execute with their limbs, involuntarily and sometimes quite without their knowledge, a great number of movements over which they have no control. These movements are designated according to their character; if small and separated by intervals, or very small and continuous, or, on the contrary, rather large and frequent, they are called tics, tremors, or choreic movements, respectively.

Tics, like many other symptoms in regard to which we have already made the same remark, are peculiar not merely to hystericals; they may exist in many other mental maladies much more grave, and may then present quite another prognosis; but it is unquestionable that they are equally frequent with hystericals.[1] M. Charcot

[1] Charcot, *Arch. de neurologie*, 1892, p. 85.

describes hysterical facial tics,[1] under the name of rhythmic spasms and respiratory spasms. M. Pitres describes a great number of phenomena of the same kind.[2] M. Lasègue's fine description of the hysteric cough is well known.[3] One of the patients whom we studied, Mich., presented a fine example of this spasm, which, it seems to us, might be classed among the tics. For more than six months she coughed all day long; there was no interruption except at night, when in the profoundest sleep; her cough is of marvellous regularity; there is always a big cough, followed by two little ones; the rhythm could be represented by a dactyl (— ⏑ ⏑). The hiccough,[4] laughter, sob are so common that we need not give examples of them. M. Pitres describes analogous phenomena under the name of logospasms of the choreic type.[5] As to the tics of language, they are still more numerous. M. Jolly, in an interesting work on children's hysteria, points out many examples; the patients begin to stammer, to lisp, to talk baby talk,[6] etc. When we see Bertha adopt for entire months a queer and absurd expression, and, despite herself, interrupt her talk every moment to exclaim: "Ah gaga! ah massacre!" we think this bad habit may well be associated with a real tic of the language.

The hysterical tremors have been so well studied by M. Dutil[7] that it is needless for us to come back to their description; it will be enough to recall the conclusions of his study:

[1] Charcot, *Mal. du syst. nerv.*, iii., p. 37.

[2] Pitres, *op. cit.*, i., pp. 310, 335.

[3] Lasègue, *Œuvres*, ii., p. 1; Charcot, *Archives de neurologie*, 1892, p. 75.

[4] Guinon, *Les agents provocateurs de l'hystérie*, p. 20.

[5] Pitres, *op. cit.*, i., p. 357.

[6] F. Jolly, "Uber Hysterie bei Kindern." Sonder Abdruck aus der *Berliner klin. Wochenschr.*, 1892, no. 34, p. 3.

[7] Dutil, *Contribution à l'étude clinique des tremblements hystériques*, 1891.

The tremor [he says] is quite a frequent symptom of the great neurosis. . . . If at times it appears as an ephemeral phenomenon, as an insignificant accident among the habitual manifestations of hysteria, there are cases where it constitutes the most marked symptom, the only symptom of the malady. . . . Hysterical tremors present in general a regular rhythm; but nothing is more variable than the rapidity, the frequency of the oscillations which constitute them; some are remarkably slow—from four to five and one-half oscillations per second; others are very rapid, really vibratory—eight to twelve oscillations per second. Between these two extremes occur tremors of the medium rhythm—five and one-half to seven and one-half oscillations per second. The facts which vary this intermediary type are most numerous. There are some which appear only on the occasion of voluntary movements —purely intentional tremor. Most persist both during a state of repose and during the active movements; but they undergo sometimes, under the influence of the latter, diverse modifications in regard to the frequency and amplitude of their oscillations.[1]

M. Dutil insists on a very important characteristic from a clinical point of view, namely, the resemblance of certain tremors to those of organic origin in different nervous diseases. The first imitates the tremor of paralysis agitans and the senile tremor ; the second, Basedow's disease, the alcoholic tremor, and that of general paralysis; the third recalls either the spinal epilepsy of the spasmodic paraplegiacs, or, when it exists only in intentional movements, one of the characteristic symptoms of the sclerosis *en plaques*. Such was precisely the aspect of a patient whom we studied at M. Hanot's. God. had for years been afflicted with a general and well-nigh continuous tremor. But the tremor, although it does not completely disappear, is very slight, scarcely perceptible during complete repose. On the contrary, it increases

[1] Dutil, *op. cit.*, p. 9.

during motion, and especially during the voluntary movements of the right arm, so much so that the patient cannot carry a glass to his mouth. If we add that the limbs, particularly on the right side, show a certain stiffness, that the patient has attacks of vertigo, and that the tremor of the head makes his speech jerky, it will be understood that the diagnosis of sclerosis *en plaques* seems likely, and must even have been held in the various services where this patient was treated. However, if we observe that the reflexes are normal, that the movements of the eyes are not accompanied by nystagmus, that the right side of the body is anæsthetic, that the visual field of both eyes is reduced to ten degrees, in short, that the patient presents a mental state quite characteristic (continuous amnesia, suggestibility, provoked hallucinations, etc.), we may conclude, we think, that the case is purely hysterical. M. Souques has taught us the diagnosis of these hysterias which simulate sclerosis *en plaques*.[1] M. Dutil insists, moreover, on the importance of these hysteric tremors, showing that certain symptoms, sometimes considered distinct maladies, must depend on them. He corroborates by convincing arguments the opinion which assimilates the mercurial tremor with the hysteric tremor.[2] M. Pitres also thinks that the paramyoclonus multiplex should be connected with a phenomenon of the same sort.[3] M. Moebius likewise held this opinion.[4]

The hysterical choreas have played a great part in history; the turning, climbing, jumping varieties were met with in all great epidemics of possession.[5] They have

[1] A. Souques, *Études des syndromes hystériques simulateurs*, 1891, p. 16.

[2] Dutil, *op. cit.*, p. 96; *cf.* Pitres, *op. cit.*, i., p. 366; Gilles de la Tourette, *op. cit.*, p. 473.

[3] Pitres, *op. cit.*, i., p. 333.

[4] Moebius, Ueber den Begriff der Hysterie, aus dem *Centralblatt für Nervenheilkunde*, von Dr. Erlenmayer, xi., 1888, no. 3, p. 6.

[5] *Cf.* Regnard, *La sorcellerie*, 1887, 40, 70 *passim*.

generally an established character — rhythm, well described by MM. Germain Sée, Trousseau, Briquet,[1] Charcot.[2] The movements, however varied and extraordinary they may be, are regular. Salutations, for instance, regularly repeated thirty or forty times a minute. These choreas might have been designated under the name of oscillatory or pendulous spasms. However, M. Charcot made a very important observation: If every rhythmic chorea may be diagnosed as being surely of a hysterical nature, the converse is not true. We should not deny the hysterical character of a chorea simply because it is not rhythmical.[3] Here is an example which seemed to us curious: Barb., fourteen years old, appears to present the type of the Sydenham chorea; no co-ordination in any of the movements of the limbs, without any rhythm,

that recalls the movements of a merry-andrew; the legs are worse than the arms, and their irregular movements are such that a standing posture is next to impossible; the legs and the feet have a tendency to curve inward, as if the patient were about to take the position of a squatting tailor; but they have other movements besides. The mental state of the patient calls for attention. It is, and especially has been, very singular. The woman, formerly intelligent and industrious, is now incapable of fixing her attention and understanding anything. At school, she could no longer learn anything or do any kind of work, and they were obliged to send her home. At her parents', she looked with constant amazement and questioned everything. She wanted to know what a clock was, what a bed was. She was for whole days obsessed by the same childish question, like the patients attacked by the folly of doubt. Since the chorea is well established, the mental state is considerably

[1] Briquet, *op. cit.*, p. 434.

[2] Charcot, *Mal. syst. nerv.*, i., p. 388; *cf.* Pitres, *op. cit.*, i., pp. 308, 315, and Blocq, *Les troubles de la marche dans les mal. nerv.*, 1892, p. 110.

[3] Charcot, *op. cit.*, i., p. 404.

improved, but she still remains in a state of uncertainty and continuous fear; the least thing surprises her and induces emotions that cause spells of weeping. This mental state is not a very characteristic symptom, for it is attendant upon most states of cerebral weakness. We might insist more on the particular state of sensibility in the case. Barb. is nowhere completely anæsthetic and there is no diminution of the visual field, but she is clearly disposed to forget her legs; the least absent-mindedness prevents her from feeling the pricks or movements made; she has, unless she looks, no knowledge of her choreic movements; in short, she herself remarks that the ground is soft under her, and that she is sinking into it. The evolution of the disease settles all doubt; the chorea of the legs becomes gradually transformed into contractures, and the limbs become fixed in the slight turn of the knee and in the internal rotation of the foot—a position which the choreic movements precisely tended continually to produce; anæsthesia is clearly established in the two limbs, and the emotions of the patient are transformed into real attacks of hysteria. This young girl passed through the doubt and the chorea which were followed by hysteria.

Such are, summarily recalled, the principal forms of involuntary movements; it is not necessary to dwell at any length upon their interpretation, for their eminently psychological character is almost universally admitted, and we have but to repeat a few of the discussions which have already taken place touching hyperæsthesias. If we consider the origin of these accidents, we see that they are spontaneous only in appearance; that there is always some real fact, some emotion experienced by the patient which indicates how it began. The cough of Mich. began with a real angina, probably a mild one, which yet frightened her parents very much, and which was treated with cauterisations of the throat. The barking of another patient had for its cause "a big, ugly dog, which everyone in the house caressed, and which they loved more than me." The barking of another, Qu., almost like that of the first, seems to be the exaggeration of big sighs, which she uttered continually, "because she had no hope of marriage and

was tired of living all alone." "Tics sometimes are nothing more than the faithful and involuntary reproduction of gestures executed by another person, a sort of echomatism,"[1] and M. Charcot showed that the bleating of a patient had begun in her imitating a toy.[2] MM. Breuer and Freud relate that a woman, watching a sick child whom she had had much trouble in putting to sleep, made every effort to keep quiet and avoid the least noise that could wake him. But just in consequence of this resolution, and by a sort of hysterical counter-will (so called in consequence of an association by contrast), she made a clapping with her tongue. This noise was repeated once more later, in another circumstance, where she also wished to keep quiet; hence she became afflicted with a clapping of the tongue at every emotion.[3]

We can say, with M. Pitres, that these tics, depending on hysteria, are all produced in consequence of traumatisms or moral emotions.[4] M. Dutil has shown that it is the same for most hysterical tremors which follow upon some traumatism, or fright, or any kind of moral shock.[5] This is incontestably so in the case of God., which we have studied, and the origin of the accident still makes good our diagnosis. God. was a tiler by trade; two years ago he fell from a scaffolding, which became loose under him, and by sheer miracle he succeeded in catching at a cornice, where he remained suspended by the *right arm*. His comrades were ten minutes in rescuing him. When they took him down, more dead than alive, he trembled in all his body and his teeth chattered terribly. Nothing more natural; only, the accident took place two years ago and he trembles still. This tremor, it is true, has diminished; but it reappears with violence when the patient tries to use his right arm, and, at this moment, God. still experiences fear and anguish; he still

[1] Séglas, *Les troubles du langage chez les aliénés*, 1892, p. 292.
[2] Charcot, *Arch. de neurol.*, 1892, p. 71.
[3] Breuer and Freud, *op. cit.*, p. 2.
[4] Pitres, *op. cit.*, i., p. 317.
[5] Dutil, *op. cit.*, p. 7.

fancies that he is falling and expresses it by a terrified gesture; he prefers using his left arm. Another patient, Dal., has trembled for a year past in consequence of a carriage-accident, when he came near being crushed to death. In certain cases, exceptional ones, of course, it may be asked if the tremor does not depend on an habitual action of the patient and may not be a slight chorea? Desh. was bookkeeper in a commercial house; she had to write all day long and kept groaning under the fatigue; to-day, in consequence of a state of weakness, the result of overwork, she has professional dreams as you might call them; she calls her comrades together in a loud voice, etc.; she trembles especially in the right hand. "The act of writing is particularly apt to cause tremor," says M. Dutil,[1] who has published the observation and has shown us the patient. We ask ourselves if it is not, indeed, the act of writing that caused the tremor here? It is but a supposition, which may seldom come true; the tremor being, above all, emotional. We must, of course, set aside certain cases of tremor which succeed attacks, and those that are not fixed ideas, the consequences of paresis. As to choreas, they reproduce oftenest either an habitual act, or a strange act which the patient may have witnessed. The following observations will give examples.

To demonstrate better the psychological character of these facts, we can study them in themselves, and see the characteristics they present. The great characteristic in most of these phenomena is evidently the fact that they are systematic. M. Charcot has very often insisted on this characteristic of the tics, which suffices to distinguish them from spasms or convulsions localised in one muscle. A tic is an ensemble of small movements harmoniously combined; it has sense; it expresses something; it is the sudden start caused by fright; the winking of the eyelids

[1] Dutil, *op. cit.*, p. 71.

that protect the eye; the shrugging of the shoulders; the gesture of surprise, etc. The hysterical chorea is the regular repetition of an action; they are movements malleatory, saltatory, rotatory, etc.[1] The following observation will bring this characteristic out. Mel., a little girl, thirteen years old, gentle and amiable in appearance, —no indifferent matter for the understanding of the case, —is brought into M. Hanot's service for a tremor which, for the last few days, has appeared suddenly in her arm and right leg. This tremor, or rather this chorea, for the movements are considerably extended, does not seem at first sight quite clear, for the patient mixes voluntary movements with the choreic movements; but when she is abed, and her head is resting on the left side, and when she talks with someone who entertains her, the choreic movements become clear and intelligible. They are very rhythmic; the foot bends and stretches out regularly, as in a pedal motion; the hand, half shut, turns around the wrist, as in a wheel motion. We are told that the patient works in a workshop, at a curious trade; she makes doll's eyes, and it appears that with the foot she works a pedal, and with the hand a wheel. The chorea accordingly repeats professional motions, but why does it reproduce them in this manner? At night the patient dreams aloud; she groans and murmurs: "I must work, I must work," and the choreic movement goes on briskly under the coverlet. In talking with the young girl, we learn that the parents are poor, that one evening, the children having gone to bed, they talked about their difficulty in earning their daily bread and paying their rent. Mel., but half asleep, heard and began to reflect over it: "I must work, I must work," became the burden of her thoughts, and foot and arm began to work. Fortunately, by some simple processes, this chorea, due to filial piety, was stopped.

[1] Charcot, *op. cit.*, i., p. 393.

Another clinical characteristic permits us to connect these movements with subconscious psychological phenomena, as M. Gilles de la Tourette observes; it happens that disorders of sensibility and particularly anæsthesias follow spasms.[1] All the sensations connected with an arm or an eyelid issue from personal perception and are connected with an unconscious fixed idea.[2]

If we go a little beyond the simple observation, and add a few experiments, we shall be able to give precision to this psychological interpretation and again make evident the rôle of the fixed idea. These involuntary motions, like many hysterical accidents, seem to us to present themselves in two ways. At one time the patient knows very well what he is doing; he feels his arm move, he pays attention to it[3]; when he is asleep, or his mind absorbed in something else, the tic or the chorea stops. The question here is a conscious, fixed idea, which the patient will be well able to explain himself. "I think that I am in trouble," says one. "I still think that I am falling from the roof," says another. But very often it is not like this; the patient cannot explain his tic; he thinks of something else; he is absent-minded, and yet the tic has full play. We have to penetrate into the profoundest depths of the mind. The two following observations need no comment:

Lec., already attacked with hysteria, goes to an electro-therapeutic séance; she comes back with St. Vitus's dance in all the limbs, executing disordered movements. She cannot explain her condition, does not understand it; she confesses vaguely that she saw someone with the St. Vitus's dance, but does not know why she imitates it. We put her into the somnambulic state, which is easy, and the patient, with much lucidity, with an astonishing clearness of remembrance, relates what

[1] Gilles de la Tourette, *op. cit.*, p. 379.
[2] *Autom. psychol.*, p. 282.
[3] Séglas, *Langage*, p. 292.

has happened. Having seen one afflicted with the St. Vitus's dance, she began to meditate on the subject: "It is a pity; she is pretty; . . . how disfigured now, . . . one cannot really love a girl like that. . . . If this should happen to me, Charles would no longer love me, etc. . . ." She protests that she has the poor sufferer ever before her eyes, and yet, when awake, she affirms the contrary. We see here distinctly the subconscious dream producing the condition; it will suffice, however, to modify this dream and the chorea will be suppressed. The patient, Vel., does not present incontestable hysterical stigmata (be this said, by the way, because the patients cited in this work present all the classical stigmata), yet we consider Vel. hysterical, for we see in him a very clear somnambulism, quite distinct from the waking state—besides subconscious acts and even automatic writing. Now, this undoubling of the personality, as will be shown at the conclusion of this book, seems to us essentially to constitute what is called hysteria. Vel. is a young man twenty-four years old—intelligent, but nervous, impressionable, without a will of his own; he has already had fixed ideas of various kinds. In consequence of a typhoid fever, which came upon him at sixteen, he presented a very disagreeable facial tic; he twisted his face in order to blow violently through his right nostril. The grimace, at first very prominent and general, gradually took a more decided shape, and at the end of five or six weeks the tic ended in a noisy and jerky blow through the nose, with contraction of the right cheek. All imaginable treatments were tried, and yet the tic remained the same for eight years. To this day the thing occurs almost every five minutes in the day and often at night during the patient's sleep. The tic persists, despite all efforts to divert the patient's mind therefrom, and the patient himself has no explanation for it; he thinks, from what he heard his parents say, that

strong nose-bleedings have had something to do with it, but has no personal opinion on the matter. The man is very easily hypnotised, goes very quickly into a second state of which he will later have no remembrance, and he will at once affirm, as the most certain and most natural thing in the world: "I have a crust in my nose and it troubles me." No matter at what time he is put to sleep, he affirms the same thing. It is probable that this idea, more or less clear, altogether unknown to the patient, existed in his mind for eight years. This fancy has been modified and even very easily suppressed during the somnambulic state. This easy success is singular for a fixed idea of so long a duration; the tic has completely disappeared.

Fixed ideas, then, are connected with motor as well as with sensory phenomena. Tics, tremors, hysterical choreas, seem to us but another aspect of fixed ideas.

§ 4—PARALYSES AND CONTRACTURES

There will be *paralysis*—says M. Paul Richer—every time the muscular fibres shall have lost the faculty to shorten under the influence of the ordinary stimulants used in the case. . . . Contracture is defined as follows: a motor-impotence, accompanied by a persistent and involuntary rigidity of the muscles, without notable modification through the electric reactions and without alteration in the texture of the muscular fibre itself.[1]

In a word, in paralysis the members fall back flaccid, the muscles are soft and relaxed; in contracture the members keep a fixed position, which it is difficult to modify; the muscles are hard and contracted; but in either case the subject has equally lost the power of moving his limbs by an effort of his will. These two phenomena, then, resemble each other by a principal characteristic;

[1] Paul Richer, *Paralysies et contractures hystériques*, 1892, p. 1.

they alternate and intermingle closely; they are produced in the same conditions, present the same varieties, and raise the same problems. Certainly, in a complete clinical study, these two accidents should be distinguished and analysed separately; but, since we wish to make here simply a general review of psychological phenomena which accompany hysterical conditions, we have thought it well to consider paralyses and contractures in one and the same study.

Paralyses and contractures are among the most interesting symptoms in hysteria; they often constitute alone very painful and very enduring infirmities; they are often a cause of errors of diagnosis and of questionable surgical interventions.[1] They become mixed up with many other phenomena of the disease. When a hysterical complains of pains, of difficulty of motion, speech, deglutition, of digestive or even respiratory disturbances, it is not rare to discover, here or there, a contractured muscle which provokes and keeps up the symptoms. On the other hand, the study of these facts has had a great historical importance, for it has given birth to the first exhaustive works on the psychical conditions of the neuroses, namely, to the Charcot lectures of 1884–1885. This study is still to-day far from being concluded, and it gives rise to curious psychological problems, which are far from being solved. We do not, therefore, pretend in any way to explain all hysterical paralyses; we put aside, as we have always done, the simply organic phenomena which may intervene, and we speak only of a group of paralyses, those which may be justly considered as cerebral—namely, as psychologic. Even in regard to the latter, we shall be content to offer a résumé of some descriptions and a few hypotheses which seem to us to be legitimately applicable, not to all, but to a few of the observed facts.

[1] Charcot, *op. cit.*, iii., p. 275.

Paralyses and contractures are very varied, but it is interesting to notice that they almost always find a place in groups already known. They present the same varieties and may be ranked in the same classifications with all the other phenomena already described, such as anæsthesias and amnesias.[1] They may be *systematic*, *localised*, or *general*. We shall insist especially on the first, which, from our point of view, are particularly important.

1. Let us, then, first examine the *systematic paralyses*. It seems to us certain that in many cases the patients have not wholly lost all the movements of a limb; they have simply lost the power of effecting such or such category of movements, while they have well-nigh completely preserved the power over others. Certainly, in cases of this kind, there may sometimes be established a general weakening of all the movements, even of those that are preserved. This enfeeblement, which, besides, does not exist in all cases, is related to the common amyosthenia of hystericals. Yet is there none the less a very appreciable difference between the preserved movements and the lost movements, since the first, although enfeebled, still exist, and the second no longer exist at all. This loss of certain movements is not due to the complete paralysis of such or such muscle, for all the muscles are able to work in other movements. It is certain combinations, certain systems of muscular contractions, that have disappeared. It is for this reason that such paralyses have often been described under the name of systematised paralyses. M. Babinski, in publishing very interesting examples of these phenomena, observes that the word "systematic" would be a better term.[2] He recalls that to systematise designates an act, "bring facts back to a system," and that systematic applies simply

[1] *Autom. psychol.*, p. 335.

[2] Babinski, "Paralysies hystériques systematiques," *Bulletins de la Société médicale des hôpitaux*, 28 octobre, 1892.

to things which belong to, which relate to, a system. Although there is no great difference between the two terms, we acknowledge the correctness of this observation, and we designate these phenomena by the name of systematic paralyses.

The most known and the clearest among these systematic paralyses are the disturbances of the walk indicated by MM. Charcot and Paul Richer in 1883,[1] and described in 1888 by M. Blocq under the name "astasie-abasie." M. Blocq to-day brings together under the name of dysbasias an ensemble of disturbances of the walk of which the astasia-abasia is the type. "It is," says this author, "a morbid state in which the impossibility of the vertical posture and of the normal walk contrasts with the integrity of the sensibility of the muscular strength and the co-ordination of the other movements of the legs."[2] The patient, lying on his bed, can raise his legs, bend his knees, resist movements communicated in a way absolutely normal, apparently; but if he tries to rise, to stand, to walk, his legs give way under him.

In some cases particularly curious, the subject retains the power of jumping, dancing, walking on all-fours, hopping on one foot, etc. He is paralysed in only one single act, normal walking.[3] This (syndrome), as may be readily seen, is very varied; at one time it is pure, as in the preceding paralytic form; at another it is accompanied with other phenomena. This motor inco-ordination, accompanied with sharp pains, may, in very rare cases, simulate tabes.[4] Sometimes it is found that the subject, at the moment when he tries to walk, experiences an emotion, an anguish analogous to that which

[1] Pour la bibliographie et la description complète de ce syndrome, *cf.* Paul Richer, *op. cit.*, p. 48; Paul Blocq, *Les troubles de la marche dans les maladies nerveuses*, 1892, p. 55, et la thèse récente de Pierre Jolly, *Contribution à l'étude de l'astasie-abasie*, p. 9 (Lyon, 1892).

[2] Paul Blocq, *Archives de neurologie*, 1888, and *op. cit.*, p. 56.

[3] Pitres, *op. cit.*, i., p. 459.

[4] *Ibid.*, p. 471.

would drive an agoraphobe to cross a public square, and gives to the syndrome a clinical aspect comparable to that of obsessing ideas; it is the emotive dysbasia of MM. Dinswanger and Séglas.[1] In other cases may be observed phenomena of aboulia, indicated by M. Régis. It is no rare thing, moreover, to find the dysbasia accompanied by systematised chorea, which may be considered, as we have demonstrated in the preceding paragraph, a veritable, fixed idea. Rem., paralysed for ordinary walking, can, however, walk on tip-toe, as if she were in constant fear of crushing fragile objects. Finally, MM. Weill and Pierre Jolly have noticed [2] that the dysbasia of certain patients may be instantaneously stopped by compressing certain parts of the body. This fact recalls the influence of certain sensations meant to stop or provoke the automatic phenomena of hysteria.

Besides the astasia-abasia, other systematic paralyses are known, less frequent perhaps, but quite as significant. A patient described by M. Babinski could stand up and walk, but was altogether unable to execute voluntarily the elementary movements of flexion or extension of the foot, leg, or toes.[3] It is a systematised paralysis of all the general functions of the lower leg, with the exception of that of walking; it is the reverse of abasia.

By a delicate analysis of certain cases of facial paralysis, the same author was able to demonstrate another systematisation. The movements of the commissures of the lips are very easily executed on both sides when the subject is requested to put each side into movement separately, but when the patient speaks or tries to whistle there is but one side of the face, the left, that normally contracts. The commissure on the right side remains

[1] Séglas, "De l'abasie et de l'astasie emotives," *Médecine moderne*, 1891, no. 24.

[2] Weill, *Archives de neurologie*, 1892, p. 89; Pierre Jolly, *op. cit.*, p. 23.

[3] Babinski, *Soc. médicale des hôpitaux*, 8 juillet, 1892.

immovable. " There is here a contrast between the integrity of a system of movements which one muscular group is called upon to execute and the abolition of some other system of movements, the execution of which is entrusted to this same group of muscles." [1]

The disorders which have been described by the name of external ophthalmoplegias of hystericals [2] seem to be of the same kind. The patients seem to have lost the power of effecting alone a certain movement of the eye, a look to the right, for example; but it may be proved that, in many circumstances, this movement may nevertheless be effected. As a general thing the question here is not of systematic paralysis; it is only a question of the opposition between the voluntary movement and the automatic movement, which we shall find again in may other paralyses.

We shall, rather, point out as systematic paralysis certain forms of hysterical mutism. " Certain people are dumb without being aphonic, others are aphonic without being dumb. One patient may be able to blow and whistle; he has only lost the motor-representations necessary to put into play the mechanism of the articulate word." [3] " A patient is absolutely dumb," says M. Babinski, likewise, " and yet tongue and lips move easily to accomplish functions which do not belong to language." [4] A patient of M. Oppenheim's can no longer speak, but utters cries of pain when pinched; she can also sing loud.[5] A child, of whom MM. Breuer and

[1] Weill, *Archives de neurologie*, 1892, p. 89; Pierre Jolly, *op. cit.*, p. 23.

[2] Ballet, *Revue de médecine*, 1888, pp. 337, 513; F. Raymond et E. Koenig, "Sur la dissociation des mouvements oculaires chez les dégénérés hystériques," *Annales d'oculistique*, juillet, 1891.

[3] Charcot, *op. cit.*, iii., p. 427; *cf.* Blanche Edwards, *De l'hémiplégie*, p. 103.

[4] Babinski, *Migraine ophthalmique hystérique*, p. 4.

[5] Oppenheim, *Thatsächliches und hypotetisches ueber das Wesen der Hysterie*, October, 1889, p. 1; même observation par Gerhardt de Wurtzburg, P. Richer, *op. cit.*, p. 207.

Freud relate a most interesting fact, " was a little frightened at night; she cannot speak, and tries to recall a prayer to recite. Just at that moment she cannot find in her memory any other except a child's prayer in English. This child remained dumb for a year and a half; she can neither speak, nor write, nor even understand her mother tongue, but she understands, speaks, and writes English. Is not this a fine case of systematic mutism ? " [1]

The same characteristic, the same systematisation, may be met with, to my thinking, in contractures.

There are [as we have said before] *systematic contractures*—that is to say, contractures in which all the muscles of the arms or hand are not exactly contractured, to the highest degree, but in which only some are more or less contractured, so as to give to the limb an attitude equally rigid but expressive. The arms, for example, might remain contractured in a menacing or a praying posture.[2]

We related the example of a woman who lifted her fist against her husband and who, by a celestial punishment, is keeping her arm contractured in the position of dealing a blow with the fist. We presented, also, as of the same kind, Lem.'s case. This young man, sailor on a merchant-vessel, who already had had hysterical accidents, received upon the chest and abdomen the shock of a barrel rolling on the deck. He was not hurt, but he remained bent forward by a permanent contracture of the muscles of the abdomen and thorax. He had kept this singular position for six weeks, when Dr. Pillet, chief physician of the hospital, showed him to us. We may now add other examples. Margaret has had for a year her right hand contractured in the position of a hand that holds a needle. Justine, in circumstances which we shall study, had her hands contractured in the position a pianist would give them in trying to stretch an octave.

[1] Breuer et Freud, *op. cit.*, p. 2. [2] Breuer et Freud, *op. cit.*, p. 2.

Many other examples are of the same sort, and would show us that systematised contractures are not only met with in experiments of suggestion, but that they are often produced in a natural manner.

We have, in a general way, seen in these systematic conditions something analogous to the characteristics already studied in respect to the anæsthesias and amnesias of the same kind. The limb is not entirely paralysed or contractured in a brutal manner; it is a function, and above all an intelligent function, of the limb, which acts separately from the others. There is a delicate distinction made which awakens the idea of a selection of a thought, rather than of a gross lesion of the organism.

2. Localised paralyses do not affect an isolated muscle, but a member or part of a member; they are complete and suppress to the same degree all the movements of this member. Most of these cases of hysterical monoplegias have found their résumé in Miura's work.[1] Generally, these monoplegias develop after a traumatism, or an accident befalling a particular member. Immediately after the accident, or oftener after a certain period, which has been justly called *period of meditation*, the member becomes more or less completely inert.

As the traumatic action we speak of is often very slight—said M. Brodie, already in 1837—and in apparent disproportion with the effects produced, the latter are often badly understood, badly interpreted; they are taken for something very different from what they are in reality.[2]

M. Charcot has shown how this most important diagnosis should be made.[3] He insisted, in the beginning, on the

[1] Kinnosuke Miura, "Sur trois cas de monoplégie brachiale hystérique," *Archives de neurologie*, 1893, i., p. 321.

[2] Brodie, *Illustrative Lectures of Certain Local Nervous Affections.* London, 1837.

[3] Charcot, *op. cit.*, iii., pp. 288, 293, 302.

absence of fever, and on the ordinary absence of trophic lesions and of reaction of degeneration, which, in a paralysis of organic origin, should manifest themselves in a few days. He insisted on the preservation of tendon-reflexes, and, above all, on the repartition of the anæsthesia. These anæsthesias in geometrical segments do not correspond to anatomical regions supplied by a nerve-trunk, but to entire organs such as they are conceived and limited by popular custom.[1] They have the shape of a vest-sleeve, of a leg of mutton, of a cuff. It is not only the arm supplied by the brachial plexus that is insensible and paralysed; it is also the region of the shoulder, which indeed depends on the cervical plexus. The thigh and the buttock are attacked, but the sacral region and the genital region are respected, a fact which does not occur in spinal paralyses.[2] These characteristics present, it is true, some exceptions and irregularities. Atrophies and even disturbances in electric reactions have been pointed out.[3] Hysterical monoplegias, in which sensibility has been preserved, have also, though rarely, been demonstrated. M. Miura[4] pointed to a case in 31, that of Roug, which was this year the subject of one of M. Charcot's lectures. These exceptions are rare. A hysterical monoplegia has generally a special aspect; one is particularly struck by its complete insensibility, its loss of tactile and muscular sense; the indifference of the subject who has no longer any consciousness of the existence of his arm, "who has forgotten it, who has lost it." This attitude of the subject is scarcely seen outside of hysteria.

It is useless to insist on *contractures localised* in such or such organ. The contractures of legs, arms, the coxalgias, the contractures of the thorax with respiratory

[1] *Stigmates mentaux de l'hystérie*, p. 12.
[2] Souques, *Syndromes hystériques simulateurs*, p. 80.
[3] *Cf.* P. Richer, *op. cit.*, p. 9.
[4] Miura, *op. cit.*, p. 326.

disturbances, the stiff-neck, the contracture of the masseters, glosso-labial spasm, blepharospasm, the troubles of ocular accommodation, the spasms of the viscera, principal among which is the pharyngo-œsophageal spasm, are well-known phenomena.

We only regret not being able to study here in detail the observations which lead us to suppose the existence of a spasm of the diaphragm. Hysterical meteorism is not always due to a paralysis of the tunics of the intestine; it often depends in a large part on spasmodic phenomena that take place in the diaphragm. This is the opinion maintained by M. Talma, of Utrecht, then by M. Bernheim, which to us appears, in great part, very exact.

Certainly,— says M. Bernheim, — the mechanism of this swelling is not made quite clear; for the pathological lowering of the diaphragm by a pleural exudate does not usually produce so notable an increase of the circumference of the abdomen. Perhaps there is also required a particular state of the abdominal musculature which loses its tonicity and allows itself to be distended by elasticity like an india-rubber ball ? [1]

But it is evident that the diaphragm plays a great rôle in this phenomenon. The astonishing rapidity with which, by a simple suggestion, one can produce the swelling out or lowering of the abdomen without there being any passage of gas; the lowering of the diaphragm and of the inferior lobe of the lung on the axillary line established by percussion during meteorism, the disturbances of the breathing which become only higher costal after a few deep inspirations have produced the phenomena—show us the correctness of this interpretation. We shall add that with a patient, M., we have demonstrated that all phenomena which depend on the diaphragm, such as laughter, sobbing, hiccough, could not be produced

[1] Bernheim, *Hypnotisme, Suggestion*, 1891, p. 187.

during the meteorism, and if they were brought about through suggestion the abdominal swelling would disappear. It is useless to point out the rôle which these diaphragmatic spasms play in the " phantom-tumors," and in imaginary pregnancy.

3. The paralyses, more or less general, which are not confined to one limb, but which take the hemiplegic and paraplegic forms, or, in exceptional cases, a quadriplegic form,[1] present about the same characteristics as the preceding forms; yet it seems to us that they should be distinguished from them, for, in certain cases, they cannot be interpreted in the same way. Facial paralysis is met with, as MM. Ballet and Babinski[2] have shown, but it is much more rare in the hysterical hemiplegia than in the organic hemiplegia. The energy of the non-paralysed side is not affected. It remains intact, or even increases sometimes instead of diminishing, as in organic paralyses.[3] In short, one may establish here, in a supreme degree, the great characteristic of hysterical paralyses, of anæsthesia, and even of the amnesia of paralysed limbs. " The patient sweeps the ground," said M. Todd. " He drags his limb after him," said M. Charcot; " he may be designated by the name helcopode." " He drags his leg," says M. Blocq, " as if it were a foreign body fastened on him without his knowing it!"[4]

Contractures appear to us *general* when all the muscles of one limb are contractured to the highest degree, so as to give to the limb a regular posture, always the same, determined by the unequal force of the different antagonistic muscles. The lower limb is stretched out,

[1] P. Richer, *op. cit.*, p. 177.

[2] Babinski, " Paralysie faciale hystérique," *Bulletins de la soc. méd. des hôpit.*, 28 juin, 1892; Blanche Edwards, *De l'hémiplégie dans quelques affections nerveuses*, 1889, p. 163.

[3] Féré, *Sensation et mouvement*, 1887, p. 28; Pitres, *op. cit.*, p. 204.

[4] Blocq, *op. cit.*, p. 82.

adducted, and slightly rotated inwards, the foot, in equino-varus, slightly bent inwards, with the toes much flexed. The position of the upper limb is more open to dispute. M. P. Richer gives as the most regular form the forearm flexed on the arm. We have much oftener observed, in general contracture, the arm held tight to the body, the forearm extended and slightly rotated inwards, the fist clinched without the position of the thumb presenting anything very characteristic. These positions are very frequent; for contractures, even systematised, have often, at the end of a certain variable length of time, and according to the subjects, a tendency to become general and the limbs assume then a regular position. It is none the less true that at the beginning, and often for a considerable time, the diverse forms of contractures are quite distinct from each other.

1. *Paralyses and hysterical contractures depend on psychological phenomena.*—If we reflect on the characteristics of these different varieties of paralyses and contractures, we shall easily become convinced of the notion, now generally admitted, namely, that they do not depend on a material and enduring lesion of the nerves of the cord or brain, as M. Charcot demonstarted in his lectures of 1884, 1885. The condition, probably, is one of those transitory modifications of the cells of the cerebral convolutions which manifest themselves in the form of a psychological disturbance.

The beginning of these phenomena agrees with this supposition. The provocative causes are almost always accidents which have not brought with them great physical traumatisms, but which have been accompanied by a strong moral emotion. The patient of Dr. Despine (of Aix), who had been paraplegic for two years, had had a fall from a height no greater than her own, and found herself seated on the ground; a very inconsiderable fall, which yet became complicated in her mind, she being a

child of eleven years old, with the purpose to conceal the accident from her mother, and not to tell her that she had quarrelled with a little friend. One of M. Charcot's patients pretends that a carriage had passed over his left leg, although in reality he had been simply bruised. A hysterical woman, described by M. Souques,[1] imitates exactly the paraplegia of a syphilitic woman whom she had seen near her. M. Gilles de la Tourette relates that a woman, boxing a child's ears, remained paralysed in the act with an anæsthesia *en manchette*.[2] A man, R., being present at the burial of his nephew, who had had his arm cut off after a factory accident, returned home with a hysterical monoplegia. An individual who was working in lead imitated the paralysis of the extensors of his comrade, etc. It is the same with contractures: the patient we spoke of had her hand contractured as she threatened her husband with her fist. Lem. was struck by a barrel which rolled over the deck of the ship, but he received no hurt. Justine's contractures have commonly nothing but dreams for their origin. She had dreamt all night about her piano and had her hand contractured in the position of reaching an octave. She dreamed that she was moving away with her furniture and that she was constantly ascending stairs. When she awoke she had a contracture of the legs in flexion as if she were ascending steps. She dreamed that she was obliged to walk on her head, and she awoke with her two hands contractured above her head, etc. A patient, cited by M. Guinon, presented a blepharospasm because he had got a grain of sand in his eye.[3] Let us add that, generally, the conditions are not produced immediately after the provocative cause, but that there is a certain lapse of time before the accident is clearly defined. This lapse of time has been quite correctly called the period

[1] Souques, *op. cit.*, p. 87. [2] Gilles de la Tourette, *op. cit.*, p. 522.
[3] Guinon, *Agents provocateurs*, p. 310; P. Richer, *op. cit.*, p. 9.

of meditation, for it is very likely that the subject employs it in meditating over his accident.

The end, the cure of such accidents, suggests to us the same thought. It is well known that they may disappear after an emotion, a dream,[1] a suggestion. Lem., contractured for six weeks, was cured in a few minutes. Justine loses her contractures as soon as you shake her by the hand. Electric sparks and even the famous "insufflation" upon the region where the principal trunk of the nerve passes, practised by old hypnotists, was not due to any other action. "Massage," remarked M. Charcot formerly,[2] "produces a sort of local hypnotism," or simply diverts the attention of the subject, imposing new muscular sensations upon him which give him back the use of his limb.

While these phenomena exist, we shall remark that they may last very long without being accompanied by these modifications of reflexes[3] of electrical reaction, by those trophic disturbances which are not slow in manifesting themselves after lesions of the cord or the encephalon. We shall observe that the localisation of these accidents in the shoulder without participation of the arm, in the two members of one side without participation of the face, does not seem to be *en rapport* with the structure of the nervous system, and that the singular limitation of paralyses and anæsthesias is far more connected with popular ideas than with anatomical boundaries. In many cases, the systematisation is more surprising still, and altogether unknown in the clinic of the organic lesions. We shall be astonished to see as complete paralyses, insensibilities as absolute remaining nevertheless as limited. Finally, the indifference of the patients, the almost constant absence of pains, the disappearance

[1] Souques, *op. cit.*, p. 98.

[2] Charcot, *op. cit.*, iii., p. 398.

[3] Babinski, "Paralysies, contractures organiques et hystériques," *Soc. méd. des hôpitaux*, 5 mai, 1893.

of the accidents during chloroform narcosis, will cause us to think also of a mental trouble. M. Babinski, after similar remarks, concluded that the hysterical contracture may be compared to a state of prolonged voluntary contraction, that, like paralysis, it might depend on a psychological state of the subjects, who are unable voluntarily to cause certain muscles to pass from one to the other of these two states of equilibrium, relaxation and contraction.[2] Therefore *psychological troubles play the greatest rôle in these phenomena.*

2. *The psychological phenomena on which depend these conditions are amnesias.*—Let us endeavour now to state precisely the nature of these mental alterations. Many authors are inclined to see in paralyses troubles of will and attention. "In hysterical paralyses," M. Brodie has already remarked, "it is not the muscles that do not obey the will, but it is the will that does not act."[3] We have sufficiently insisted on the importance of the troubles of the will and the attention in hysteria to admit without hesitation that disturbances of this kind play again here a great rôle; but we do not think that this formula is sufficiently exact. Aboulia, even the most intense, as was that of Marcelle, is not paralysis; it disturbs especially the new movements, but it allows the subject to reproduce, without difficulty and even with consciousness, old movements. Now, patients afflicted with paralysis cannot reproduce any movements, even old ones. A gap of this kind in consciousness, as M. Rey Régis remarked in 1789,[4] seems to us to come rather nearer *amnesias.*

Paralysis — we said in former years — must in fact be an amnesia—the movement of the limbs being, as we have already

[1] Charcot, *op. cit.*, iii., p. 377.

[2] Babinski, *op. cit.*, p. 16.

[3] D'après Gilles de la Tourette, *op. cit.*, p. 285; *cf.* Séglas, "Abasie et astasie émotives," *Médecine moderne*, 1891, no. 24.

[4] Rey Régis, *Histoire naturelle de l'âme*, 1789; D'après Charcot, *op. cit.*, iii., p. 464.

seen, determined by a succession of certain images in the consciousness; to lose the movement it suffices to forget these motor-images. Really, these two things, forgetfulness and paralysis, are but one and the same phenomenon considered from two different sides. . . . A hysterical woman, paralysed like V., for example, can no longer succeed in calling up the visual or muscular image of her leg in motion.[1] . . . After having closed the eyes of the patient,—said M. Féré, also,—we requested her to try to picture to herself her left hand (the paralysed hand) executing alternate movements of flexion and extension; she could not do it. Yet she can perfectly picture to herself her right hand executing very complicated movements on the piano, while with her left, it seems to her, she says, that her arm is lost in a void; she cannot even picture its form to herself.[2]

M. Binet formerly remarked that things are not absolutely identical when the question is contractures. "The patient cannot think of her hand otherwise than closed."[3] The loss of memory is, however, also proved.

Finally, this conception is again confirmed by the investigation of the processes which best succeed in curing these paralyses. You show the movements to the subject; you make him execute them with the sound limb; gradually you make him repeat them with the paralysed member; in a word, you teach him over again the movements he has forgotten.[4] The various authors who have spoken of astasia-abasia, and M. Blocq[5] in particular, agree also in recognising that the point is forgetting the motion of walking. We believe that it is always so. The subject is no longer able to picture to himself the movements of his arm or leg; he has forgotten all that relates to these members.

3. *First hypothesis on the origin of this amnesia, the ex-*

[1] *Autom. psychol.*, pp. 347, 362.

[2] Féré, *Pathologie des émotions*, 1892, p. 143.

[3] Binet, *Revue philosophique*, 1889, i., p. 167.

[4] Charcot, *op. cit.*, iii., p. 361. [5] Blocq, *Les troubles de la marche*, p. 62.

haustion of the centres. — Different authors will easily agree, we think, on this first point, but not so if we try to go further and endeavour to understand *by what mechanism this amnesia* of motor-images *is produced.* We meet, in fact, at the outset, a very simple theory, which unfortunately does not seem to give us an exact explanation of the majority of hysterical paralyses. The subject, it is said, has forgotten certain motor-images; the reason is that these images no longer exist; the centres which produced them can no longer bring them forth; they are not destroyed, but they do not operate any more; they are *completely exhausted.* The patient suffering from hysterical mutism necessarily differs, of course, from him who is speechless from cerebral softening; in this sense: that in the case of the first, the loss of the verbal images is instantaneous, and in that of the second, irreparable. But in reality they are similar; they have the same complete break in their psychological phenomena. It is thus that M. Oppenheim seems to understand these paralyses when he connects them with an abnormal exhaustion of the nerve-centres determined by a greater "*molecular-labilität.*" The organ is more excitable and reaches more quickly this degree of stimulation, which paralyses the function.[1] This opinion is also generally shared by M. Féré:

> These paralyses, he says, are not, we think, due to either a shock or an idea, but only to fatigue, or exhaustion, . . . the idea plays but an accessory rôle in their production; . . . these paralyses are due to a central exhaustion caused by an excessive expenditure of nervous force.[2]

He demonstrates this interpretation by giving several interesting observations; In one, a young girl practises industriously a piece of music which she is to play at an

[1] Oppenheim, *op. cit.*, 1889, p. 6.

[2] Féré, *Pathologie des émotions*, 1892, pp. 145, 149.

anniversary; *right on the eve of the ceremony* she is struck with a flaccid paralysis in the left arm.[1] Another dreams one night that she is pursued by some men on the Odeon square. She escapes only by a precipitate flight and awakes exhausted. The next day she is seen to walk with difficulty. The dream is repeated every night for two weeks. It even occurs in the daytime, and gradually both legs become completely paralysed. "Here the weakness of motion is really produced by the gradual influence of the fatigue due to the exhaustion of the motor-centres in consequence of a rapid succession of useless motor-discharges to produce motion."[2]

This hypothesis of complete and real exhaustion of the centres of the paralysed limb, for it is only an hypothesis, may be useful and correct in certain cases; yet we think that it would not be well to rely on it too much, nor consider it a complete explanation of the facts. That which characterises hysterical paralysis is not the numbness and fatigue which follow upon a traumatism or even a dream, for this phenomenon is found in everybody. It is somewhat exaggerated with hystericals only because of the general weakness which is undeniable in their case; but that which does characterise it is that this numbness does not disappear in a short time through repose as it ought, even with the weakest persons. On the contrary, it increases, becomes transformed into a complete paralysis, and lasts for months and years. That some centre may be exhausted is possible; but why does it remain exhausted for a year? What prevents restoration and keeps up this perpetual exhaustion? And again, if hystericals are so easily exhaustible it is to be wondered that they are not constantly paralysed! Here we have motor-centres which become definitively exhausted for several months by the dream of a hard run. Why do they not

[1] Féré, *Pathologie des émotions*, p. 143.

[2] Féré, *op. cit.*, p. 152.

become exhausted at the same time by the terrible convulsions which take place with these same patients? Isabella has both legs paralysed by a slight fall; this fall then sufficed to exhaust the motor-centres of her legs; but here she is with attacks in which she moves her arms in every direction and gives herself violent blows. When she awakens from her attack, her arms feel very tired, but they are not paralysed. How is it that exhaustion strikes such or such an organ and happens at the time of such or such an event, and does not happen at such other times far more grave? A young girl who learns music has many opportunities to fatigue her left hand. How is it that the fatigue takes the form of paralysis just at the moment of the ceremony of an anniversary?

All the dreams of movement do not produce paralyses. Justine dreams that she is moving her furniture and wakes with pains, with intolerable hyperalgias in both arms. She dreams that she is practising and awakes with a systematic contracture of the hand in the position of a pianist when stretching an octave. Why should dreaming of motion produce exhaustion in one case and not in another?

Finally, what seems to us essential in hysterical accidents is the persistence of the dream. This dream does not only exist in a few particular cases, where a dream was the starting-point of the conditions; it exists always, in the day as well as at night, whether the subject can account for it or is ignorant of it. This is the true hysterical condition, and it is not explained by the accidental exhaustion of a motor-centre.

We do not, then, believe that the idea of the local exhaustion of a centre can completely account for these phenomena. But let us consider the question now in a more general way: Can it be said that, in hysterical paralyses, there exists constantly a complete exhaustion of the motor-centres and that the motor-images can in no sense any longer exist?

A great number of facts dispose us to reject this last supposition. We know that paralyses in appearance most serious can be cured suddenly, in consequence of an emotion, by an insignificant remedy or by a suggestion. We should like to insist upon a characteristic of the same kind, already observed by several authors, which shows better still the mobility of these paralyses. At certain moments, in particular states, they disappear completely; not that they are cured, because they reappear the next instant, but a very slight modification took place in the nervous system, and sufficed to suppress them momentarily. A man, Sm., is completely paraplegic for several months. He is brought on a stretcher into M. Charcot's office. There a violent attack of hysteria develops; he drags himself on the floor, then gradually, controlled by a dream, he gets up, opens the door, and runs as fast as he can through the hospital. One day, in one of his attacks, he climbs up a spout, with wonderful skill, and takes refuge on the roof. As soon as the attack is over, he falls back completely into his paraplegic state. What an attack and somnambulism achieve here, sleep achieves for others. Rose, paraplegic in waking hours, moved about with her legs so well during sleep that she fell out of bed. M. P. Richer[1] relates a most interesting observation of M. Gouguenheim's. It agrees with our point of view. In a complete case of paralysis of the muscles of the larynx, the patient at night was able to relate his dreams aloud. M. Richer relates himself a similar case. He describes a patient afflicted with complete paraplegia in her arm and wrist. "During the night the paralysis disappeared, and the patient would move her limbs, which took various positions." In waking, the movement of the members persisted until the attention of the patient was clearly drawn to it; then it disappeared.[2]

[1] P. Richer, *op. cit.*, p. 19.

[2] P. Richer, *op. cit.*, p. 207.

This phenomenon will become still clearer if we examine what takes place during induced somnambulisms. A celebrated hypnotiser, M. Despine (of Aix), gives the description of a hysterical woman, Estelle, absolutely paraplegic. It was necessary, during her waking hours, to pull her about in a little carriage. But no sooner was she in a somnambulic state than she jumped and ran about as if nothing had ever been the matter with her. "Estelle became, during her somnambulism, even one of our best swimmers. She was much pleased to give lessons to the young persons who were sometimes in the bath with her; she could dive, swim on her back, and do all the other tricks of dexterity in this kind of exercise." Awake, she was as powerless as before.[1]

We have ourselves observed a fact exactly similar in a patient, Rose—paraplegic for three months. M. Pitres describes another example of the same kind.[2] Lastly, we have just witnessed a new example. Leq. is a hysterical woman in her sixth month of pregnancy. She shows symptoms of abortion, solely caused, as we think, by the recollection of an abortion which, in a former pregnancy, took place at six months. Thanks to a few precautions, the abortion did not occur, but when the patient wished to get up she was entirely paraplegic. The legs were insensible and inert. As soon as she was in a somnambulic state she felt the slightest touch on the legs, rose and walked without difficulty. It is true that the paralysis reappears on waking; but she can be easily cured.

These facts seem to me quite important. The organic exhaustion on which the paralysis depends must be very slight, thus suddenly to disappear in the very course of the malady, and the influences capable of modifying it

[1] Despine (of Aix), *Traitement des maladies nerveuses par le magnétisme.* 1810, p. 61.

[2] Pitres, *op. cit.*, p. 406.

thus seem to me to play a more considerable rôle in the formation of the condition.

But sometimes, though rarely, for the experiment is a difficult one, it is possible to make still more significant observations. At the very moment when paralysis seems to exist, one can obtain movements simply by modifying the psychological conditions. We published formerly an observation which, we think, is still interesting and of which we ask permission to give a résumé.

Dr. Piasecki, who recently died, a victim unfortunately of his devotion during the cholera epidemic at Havre, was kind enough to take me to one of his patients, a young woman, thirty years old, V——, afflicted some weeks before with an hysterical paraplegia. . . . The legs, which were entirely flaccid and which dropped by their own weight, had lost all tactile and muscular sensibility up to the hips. . . . Motion was absolutely impossible, even though the patient looked at them. The arms, on the contrary, seemed to move easily and gesticulated constantly, but we were not long in perceiving that it was only on one condition they moved thus: V.'s eyes had to be open, she had to look at them the whole time; when her eyes were closed and she did not look at her hands, she lost the motion of both her arms and legs. . . . After having rapidly made these few observations about the subject's state of consciousness, we made a sign to Dr. Piasechi to do what we had agreed upon; he began to talk seriously with the patient so as completely to divert her attention. We ourselves stepped aside, under pretext of writing down a few words. When we saw that, according to the wont of hystericals, she had completely forgotten our presence, we commanded her, in a whisper, to raise her arm and to make such or such a gesture. While before she could not make any movement without looking at her arm, she moved it now without knowing it, and in every direction, even putting it behind her back. Emboldened by this result, we commanded her to raise her right leg, then the left, then to bend them, etc. All this was done readily and with the greatest ease. Thus her legs,

paralysed during six weeks, could easily move . . . only this movement took place subconsciously, and outside the real personality of the subject who, herself, had lost the motion of both her legs.[1]

M. Binet, in giving an account of the foregoing work, made a still clearer observation: "I add," he says, "a second proof. I have seen in a few subjects automatic writing produced by paralysed members."[2] M. Oppenheim makes remarks of the same kind.[3] These are not isolated facts, for we find them again in wholly independent observations; in the observations on external ophthalmoplegia. MM. Ballet, Bristowe, Parinaud, Raymond, Koenig, and other observers agree and recognise that, notwithstanding paralysis, the automatic movements of the eye are preserved. Celestine, a patient upon whom we have verified the exactness of these descriptions, cannot turn the eyes to the right when examined with the perimeter and requested to follow voluntarily an object which moves to the right. But it is enough to drop that object on the floor to her right to see both her eyes quickly turn to the right. These facts show us, then, one detail more—namely, that in certain paralyses, at least, although they apparently seem complete, the exhaustion of the nervous centres is not a real exhaustion, and that motion may still be produced at the very moment when the subject declares himself incapable of doing it.

4. *Theory of the development of amyosthenia and the exaggeration of the diathesis of contracture.*—The preceding experiments recall to us those which have already been described in regard to stigmata. Similar facts have been reported on treating anæsthesias and especially in respect to two alterations of movements, very important, and

[1] *Autom. psychol.*, 1889, p. 359.
[2] Binet, *Revue philosophique*, 1890, i., p. 197.
[3] Oppenheim, *op. cit.*, p. 6.

very frequent—namely, amyosthenia and the diathesis of contracture. When these stigmata exist, the voluntary movement is extremely weak, and we may ask ourselves if this enfeeblement might not end in veritable paralysis ? This is precisely the opinion maintained by M. Paul Richer, one of the authors who have most thoroughly studied this symptom. Amyosthenia, he says, increases in various circumstances, and " transforms itself at times gradually into real paralysis, or else it constitutes a favourable ground for the development of contracture." [1] This remark appears to us to furnish the explanation of a certain number of conditions.

There are, in fact, paralyses which develop without any shock, without any emotion, without any dream that might fully explain them, as M. Pitres has remarked. Here is V., for example, who remains in bed some ten days for merely a slight bronchitis. She is well attended and in no wise uneasy about either her chest or her legs. Why is she paraplegic when she wishes to get up ? The., in consequence of a misstep, has had a slight contracture which the doctor has treated by means of blisterings, a plaster cast, and continuous extension. She was in a condition to have, and did have, paralysis in the left leg; but why is she at the same time paralytic in the left arm ? Finally, why does Camilla become at times hemiplegic on her left side, and that in a gradual and insidious manner, and without any determining cause ?

The reason for these phenomena will be found, we think, if we consider the anterior state of these patients. V. had been for a long time totally anæsthetic; The. and Camilla were already deeply anæsthetic on their left sides, with loss of muscular sense. They already presented completely Lasègue's syndrome. Before their present paralysis, they had already shown real paralytic phenomena; they could not move their left side voluntarily

[1] P. Richer, *op. cit.*, p. 25.

except by looking at it; they could not move it voluntarily in the night. We have already described this intermittent paralysis of the hystericals, who have to see their anæsthetic members to realise that they are capable of movement, for they forget them completely in the dark. Is there much difference between their present paralytic condition and their former feebleness? It is only a difference of degree. The patients have lost to a still greater extent the power of representing to themselves, in their personal perception, the images relative to their left side. This increase of their normal abstraction is not even very surprising. We know that the hystericals, whose range of consciousness is very narrow, maintain in their personal perception only such elementary phenomena as are most indispensable—those that are actually utilised. Now, in the present case, the malady has still more increased this general exhaustion of the nervous system and this reduction of their range of consciousness. On the other hand, their staying in bed has prevented them from utilising their motor-images and especially the images relative to their legs and their left side; so it is quite natural that they should forget them more completely than ever.

We are the more disposed to accept this hypothesis, as it is precisely among this sort of patients that we observe most clearly the modifications of their mobility during somnambulism and the preservation of the subconscious acts, notwithstanding paralysis. We therefore think that with these patients paralytic accidents are but a development of stigmata, a particular manifestation of the general exhaustion and the reduction of consciousness. In certain cases the stigmata are accompanied by a remarkable development of subconscious acts. The anæsthetic members are disposed to partial catalepsy, in all the varieties of which they present, at the same time, an astonishing tendency to enter into contracture. Any

kind of excitation, even the slightest, induces these contractures. We do not pretend fully to explain this phenomenon, to say what share the cord or the brain takes in it; we simply know that there are mixed with it incontestable psychological phenomena, and that, notwithstanding the anæsthesia of a member, the diverse excitations provoke distinct sensations. Is it not natural that excitations of the same kind should develop contractures upon these anæsthetic and paralysed limbs, abandoned by the personality and given up to subconscious phenomena? We see, in certain cases, as in the observation of Barb., legs completely anæsthetic present alternately phenomena either of rhythmic chorea, or of contractures, or of partial catalepsy, or of paralysis. The reason is that, in fact, these different phenomena are so closely allied that they mingle intimately.

This explanation appears to us applicable to a group of conditions quite clear—namely, the paralyses and contractures which we have qualified as general; those that take the paraplegic and especially the hemiplegic form. They present a characteristic aspect and claim a distinct interpretation.

5. *Theory of paralyses and contractures through a fixed idea.*—It is quite evident that there can be no question as to applying the preceding theories to all paralyses. Many are developed in subjects who formerly had neither anæsthesia nor amyosthenia. These form rapidly, and they have a very different aspect. Instead of striking one side of the body, they affect a single member that has been the seat of a traumatism. They are *monoplegias*. In a few cases traumatism may accidentally bear upon the two members of one and the same side and produce an apparent hemiplegia, which, however, will not be identical with the preceding ones. M. Charcot, after having related the case of a man who became hemiplegic on the left side after having lain on that side at the bottom of a

well, proposes, and very justly so, we think, to call such phenomena *double monoplegias*.[1]

It is paralyses of this kind which M. Charcot lectured on in 1884–1885, and which he connected, as did M. Russel Reynolds, with phenomena of auto-suggestion, with fixed ideas. This conception evidently raises very great difficulties and does not pretend to explain all the details; but it still seems to us to-day the truest and the most general. We will try to make evident the existence of these fixed ideas.

1. These accidents, as has been seen, have a very clear beginning; they date from an accident, from some emotion which can be clearly represented in the mind of the patient. As a general thing, there was at the beginning a contusion or even a real nervous exhaustion, due to overwork. But the local nervous exhaustion is not indefinitely prolonged. If prolonged, we ask an explanation of this abnormal duration; and the fixed idea, provoked perhaps by this momentary exhaustion, intervenes to play a predominant rôle. In certain cases, even, it may be demonstrated that a small cerebral lesion took place at the beginning of the paralysis. If hysteria is the great simulator it is also the great exaggerator, and the fixed idea develops concurrently with the motor trouble, and the discomfort brought about by the lesion. It is a very fertile idea in clinics, that of the associations of hysteria and minute encephalic lesions.

2. This fixed idea, of which we have seen the starting-point, often asserts a permanent sway. It explains how paralysis or spasm may continue when "all signs of the original irritation have disappeared."[2] It gives to paralyses, and especially to contractures, their systematic aspect. What phenomenon, if not an idea, could determine those strange positions of

[1] Charcot, *Tuesday Lectures*, i.

[2] Lasègue, *Études*, ii., p. 75.

the hand, of the trunk, which seem to be the continuation of an action? When Lem. is always bent forward, does he not retain the attitude he had when the barrel, rolling on the deck, struck him on the thorax? In certain cases, one may still better catch the action of a fixed idea on the spot. Contractures seem absolutely permanent contractions of the muscles, yet in reality it is not so. Generally, in accordance with our view, when the leg is lying on the bed, when no one touches it, when the subject does not try to move it, the muscles are at rest and are perfectly relaxed. One can see and even feel under the hand the instantaneous contraction of the muscles at the moment of trying, or when the subject himself tries, to displace the limb.[1] There is, as it were, an obstinacy in maintaining the limb in a determined position. Sometimes this fixed idea is conscious, and it is necessary to deceive the subject to stop the phenomenon. Lucy had a spasm of the jaws, for which we could do nothing. Someone told her to put out her tongue to us when we should enter. The notion amused her, and we found her forgetting to keep her mouth shut, and putting her tongue out to us. M. Gilles de la Tourette relates a curious example of the same kind:

> M. Straubridge—he says—cured a hysterical blepharospasm by keeping perforce the eyelids raised by means of strips of adhesive plaster. The moral was as great as the physical effect; several times when the dressing became loose, to the knowledge of the patient, the eye remained open, whereas after the plaster was taken away, the spasm returned immediately.[2]

3. But generally the idea is subconscious and the subject is quite astonished at this stubbornness of his limbs. We must then try to penetrate into the knowledge of these psychological phenomena of which the patient is

[1] *Cf.* P. Richer, *op. cit.*, p. 87. [2] Gilles de la Tourette, *op. cit.*, p. 406.

himself ignorant. In dreams,[1] in crises, in somnambulism, we find again the initial terror, the repetition of the same accident, the same attitude of the limb. Alz. was wounded in the left shoulder by the fall of an elevator, and his arm is paralysed; but he has besides terrible attacks in which he keeps his left arm propped against the floor, while he defends himself with his right arm and casts terrified looks on his left side. He keeps exactly the attitude in which he was picked up after his fall. Pasq. presented hysterical mutism for the first time after a quarrel with his wife; his mutism is intermittent; it lasts for a few days, then disappears; but, during his periods of speechlessness, he is sombre and weeps. He has constantly before his eyes the image of his wife and experiences the same emotion, as he explains it himself very well, when in the somnambulic state, for in that state he can speak. Cap. had her thumb caught in a door and drawn in. She presented a thumb flexed and contractured, but it was curable. Very often in the morning on waking she presents the same contracture without knowing why. It is because she dreamt about her accident, as we very soon ascertain in putting her into a somnambulic sleep. It is useless to insist on examples which are all similar.

If we give up the observation, properly so called, we can verify by experimentation the rôle of the fixed ideas in the production of the accidents. With these very patients or with others we can reproduce the same accidents through suggestion or by a shock which will awaken in the mind equivalent ideas. It is not enough to say that suggestion acts like a depressing emotion, because it induces resistance in the subject. It is thus with all suggestions, even the most cheery. The depressing emotion, if produced, and the paralysis, are consequences of the suggested idea, of the psycho-physiological states

[1] G. Guinon, *Agents provocateurs*, p. 366.

which it brings along with its development, and it is always the suggested and invading idea that plays the principal rôle. Whatever standpoint you take, you find fixed ideas, more or less conscious, accompanying these paralyses and contractures.

4. What is the nature of these fixed ideas ? M. Charcot has described the simplest and certainly the most frequent—the simple idea of numbness, of impotency, of paralysis. The subject thinks that he is paralysed, and he behaves like a paralysed person. He realises his condition as he conceives it, with or even without anæsthesia, according to his idea.[1] We think that this very simple explanation is also the most true. However, other ideas may intervene and bring about paralysis in a less direct manner. Strong emotions, timidity, fright, paralyse legs without anyone expressly thinking of being paralysed. A young man, whose history M. Charcot relates, is paralysed at the moment of reading verses at an academic ceremony—a distribution of prizes.[2] Let the representtation of the scene, let the emotional state persist in the mind in a more or less conscious manner, and the paralysis will persist also.

Finally, we propose, though with more hesitancy, a third supposition. Every subconscious idea robs the principal personality[3] of sensations and images. The medium no longer feels her hand and can no longer move it while writing automatically. Bertha is obsessed by a song she sings " within her," despite herself. During this period of time, she can no longer speak. A dream, subconsciously persistent, in which the motion of a member is represented, invades her in some sort and robs the principal consciousness of the mastery of this member. Le. dreams that he is struggling with a thief and repulses the assailant with his right

[1] Charcot, *op. cit.*, iii., pp. 326, 353. [2] P. Richer, *op. cit.*, p. 17.
[3] *Revue philosophique*, 1887, i., p. 463 ; *Autom. psychol.*, p. 291.

hand, while the intruder puts his knee on the left hypochondrium and tightens his hand about his neck. He shows, on awaking, a hyperæsthetic point on his left side —a point which, if hard pressed, will bring back the complete hallucination of the scene, but it shows, besides, a plaque of anæsthesia at the neck, a complete insensibility, and an almost complete paralysis of the right arm. Why these two symptoms ? Because these sensations of pressure about the neck and movement of the right arm form, so to say, a portion of the dream, are absorbed by it, and are no longer within the control of the personality. This is only an hypothesis. It bears on only very particular cases, on the manner in which such or such a fixed idea brings about paralysis, and not on the rôle the fixed idea plays in general in these accidents.

A few objections have been made. One may, it has been said, provoke paralyses in hystericals, while they are in a crisis, or asleep, or even while acting on their anæsthetic side. These provocations act, then, physically and not morally. We are convinced, on the contrary, that a hysterical feels and presents psychological phenomena during the crisis, during the sleep, and even when she is struck on the anæsthetic side. In acting thus, the operator is put in the best conditions to make suggestions. One may, it is said again, paralyse hystericals in exhausting them by the application of a magnet or by the application of a vibrating tuning-fork on the hysterical points. We may be excused from demonstrating the enormous part which suggestion plays in such experiments, and simply refer the student to what we have already said touching the magnet and hyperæsthetic points. A more important objection is M. Grasset's,[1] namely, that experimental suggestion is not always able to undo the natural accidents of hysteria. This is unfortunately true, but we are not sufficiently acquainted

[1] D'après Guinon, *Agents provocateurs*, p. 354.

with the idea which induces the delirium and which keeps up the paralysis, the state in which the subject should be placed to reach it, the means to modify it, to cause it always to disappear. There are also experimental suggestions made in determined conditions which another operator will not be able to remove, unless he exactly knows how to place himself in the same conditions. This very just remark shows unfortunately that we have yet much to learn about the mechanism of fixed ideas; but it does not do away with their existence, and the problem invites further study.

We have thought proper to insist on these curious conditions and on the difficult questions they involve, which we are very far from having solved. Yet it seems that by borrowing from the different authors their most correct conceptions, in completing them, the one by the other, instead of contradicting them, we have been able to indicate how paralyses and contractures approximate other conditions. Local exhaustion at the beginning of the accident, general exhaustion during the whole duration of the malady which engenders suggestibility and fixed ideas, the development of certain stigmata, as amyosthenia and the diathesis of contracture, and especially the fixed ideas which alter the movements in a direct or indirect way, permit at least their partial resumption.

§ 5—General Effects of Fixed Ideas; Modification of the Stigmata

We have now reviewed some of the particular effects, effects which might be called local, of fixed ideas, and we have seen that they can produce on such or such a point of the body hyperæsthesias, choreic movements, paralyses, contractures, etc. But their action extends still farther; they are not confined to an isolated modification of a phenomenon or function; they have a most

serious influence upon all the other psychological phenomena and transform the whole train of thought.

This opinion has already been partially expressed by those who have pretended to explain the stigmata of hysteria by fixed ideas. Certain patients seem, in fact, to have a more or less clear idea connected with their amnesias or their motor weakness. Marcelle, whose abulia was so characteristic, dreamt that she was paralysed. Others, again (it has been readily noticed), present their stigmata only at the moment when they appear to have become aware of them, and they no longer show them when they are not thinking of them. We think we catch them off their guard; that they have given up playing the comedy of insensibility or of amnesia, and we conclude easily that these stigmata are a sort of fixed ideas which happened by accident.

This explanation would be simple enough. The subject does not feel, does not remember, because he suggested to himself the idea of not feeling, not remembering. Unfortunately, we have not seen so direct an influence of fixed ideas upon stigmata; the observation of a great number of very regular facts, facts easily proved, prevent our likening stigmata—anæsthesia, for example—to accidental symptoms. (1) There is always a precise event at the beginning of the accident due to the fixed idea; here we see nothing in the history of the patients which could have put into their heads the idea of not feeling anything on their left side, or of having their visual field restricted. (2) The accidents from fixed ideas are known by the patients; the stigmata are so much a matter of indifference to the patient that they are generally ignored. (3) It is true that certain fixed ideas are subconscious, but we find the thought of them in somnambulic states or by processes which permit us to prove the subconscious phenomena. Never did any of these processes enable us to establish a fixed idea concerning

stigmata. (4) The thought of the accident determines the nature of the symptom; in other terms, the patient realises a symptom as he conceives it. On the contrary, we find in the stigma complicated characteristics of which the subject has no idea whatsoever. Has he any suspicion of the strange disturbances of the movements which muscular anæsthesia brings with it? Had he a notion of this syndrome of Lasègue's, which we sometimes discover in him when he is brought to the hospital? (5) Fixed ideas, being accidental and personal, are very variable; we can not enumerate the curious tics we meet with, and we may always expect a still greater number which we had not foreseen. Stigmata are perfectly regular and have remained the same since the Middle Ages to our own time in all the countries where they have been observed. (6) Finally, we have already remarked that fixed ideas are not habitually developed, except in quite particular cases, and only at a period of the disease already well advanced. This disposition to suggestibility, to the division of consciousness, is not complete at the beginning. Now, stigmata often show themselves very soon at a period when the fixed ideas cannot have this strength and persistency.

To be sure, in certain cases, characteristics partially analogous to stigmata, anæsthesias, or disturbances of motion may be determined by suggestion. But we believe that it is not the natural development of these symptoms. As a general thing, they are not accidental, but they are the expression of a cerebral weakness, of a narrowing of the field of consciousness whose general laws we have tried to indicate.

The influence of the fixed ideas upon stigmata is of another nature; it is indirect. An idea of any kind, which seems to have no connection with sensibility or memory, determines by its presence alone a weakening of personal perception, which betrays itself outwardly by an increase

of the stigmata. The fact is quite evident and very simple if we consider conscious fixed ideas—that is to say, known and avowed by the subject—and their influence on the will and the attention. We shall indicate only one example of intense abulia kept up by a fixed idea in an hysterical. Ger. had for ten years exercised the functions of a *concierge* (doorkeeper) in the same house, and she had always shown much activity and attention to her work, although she had already had a few hysterical crises on account of violent emotions. Now, for six months, her disposition and her conduct completely changed. She gradually gave up all work; she is nearly always lying down, even in the daytime; she seems to suffer excruciatingly as soon as the least service is asked of her. Besides, she forgets about things, answers at random, and does not seem to understand any longer what you either say or write to her. She has got so far as completely to neglect her child and no longer to recognise him. Of course, all possible maladies were supposed. A physician even attributed her difficulty of motion to rheumatism, and explained all by the dampness of the yard. When we tried to account for what was inducing so intense a case of abulia we became soon aware that the patient tried to conceal something. Taking her aside, and insisting somewhat, the confession was not hard to obtain. Ger. had met a swindler who had taken full possession of her. Either by means of hypnotism, as she contends, though without proofs, or by more natural means, he had made himself thoroughly master of this very feeble hysterical. Gradually, by various pretexts, he had made her entrust him with all the money she had laid by, and then he disappeared. Ger. thought day and night of her thief, believing herself in his power, and, though robbed herself, she expected every moment to be arrested by the police. This continuous preoccupation had brought about a number of nervous disorders

and especially a complete abulia. We hypnotised this patient—less to know about her fixed idea, about which there could be no question, than to find out what the thief's former successes might have been. The woman is, in fact, very easily hypnotised, but we do not think that the thief put her really to sleep. Besides, she is so suggestible when awake that any complicated process was perfectly useless. All that was wanted was a few suggestions and, above all, sound, practical advice to put everything in shape again. The proprietor of the house undertook the detection of the thief, and Ger. was at once relieved of all preoccupation. Immediately her laziness, her fatigue, mental troubles, and even the pretended rheumatism disappeared as by enchantment. Ger. began again to take care of her child and house and recovered all her attentiveness as *concierge*.

The same observation is more difficult to make when fixed ideas are not known to the patient, but remain subconscious. Here is a rather curious example, which shows at the same time one of the dangers of post-hypnotic suggestion. M. came to see us one evening about various troubles. It was after having caused her to pass into this second state that we talked with her and gave her some advice. Then we waked her without thinking of repeating to her the same advice during the waking state. A few days later she wrote us the following letter:

I cannot understand the state I am in; I must appear very odd to people. It is so difficult for me to understand; I fancy everybody is looking at me. I have absolutely no feeling; I drop everything, which makes me look very stupid; I cannot work any more, and if they become aware of it in the house I shall be indeed badly off . . . I do not know if I am in the wrong; I have a vague remembrance that I have some work to do. I have tried for two days to find out what it all means. . . . I cannot; probably I am all mistaken. . . .

As may be guessed, it was enough to put her to sleep again to free her from this ill-made suggestion, and give her back her tranquillity and free disposal of her attention. The fixed idea belonged only to the second consciousness, since M., when awake, could not find it again and yet it provoked a general abulia. Besides, in all cases of a subconscious fixed idea, which we have described, that same perturbation of the will and of the attention reappeared.

Fixed ideas have an analogous effect on sensibility; we do not believe that, except in very rare cases, the fixed idea provokes directly anæsthesia, but it provokes it often in an indirect way. Justine has not usually a very clear anæsthesia or contraction of the visual field. She comes one day with a gloomy and ill-natured face; she answers badly to the questions put to her and does not react when pricked. We perceive that she is totally anæsthetic and that she has her visual field contracted to twenty degrees. We can obtain but little information concerning what has happened, for she tells us only that she is angry with her husband and that she had wanted to strike him with a knife. She is ashamed of the thing and cannot understand how she could have allowed herself to yield to such violence. When she is sound asleep, she relates that yesterday morning, while she was waiting for her douche, she heard about a patient who came generally with her and who had been shut up in an asylum because she wished to kill her husband; " and I also," she said,—" I am crazy and want to kill," etc. The fixed idea of the somnambulic sleep was destroyed. On waking Justine was quiet; she had at the same time recovered complete sensibility and her normal visual field. Yet we are sure we had made no allusion to her anæsthesia, but it had spontaneously disappeared along with the dream. This observation is exactly repeated in the same manner with other patients — in particular with

Maria—with this difference, that with her it is always the same fixed idea that reappears. When she is found anæsthetic we are sure that she, more or less consciously, dreams of drinking ether. The fixed idea is with many patients a great cause of anæsthesia, especially with those who are not regularly and constantly anæsthetic, and who become so only by accident or in consequence of an emotion.

Finally, the fixed idea plays a rôle still more curious in the formation of another stigma, of amnesia, and especially the variety which we have called continuous. We noticed a long time since that all patients who presented in a very clear manner this complete oblivion of recent events in the course of their development, Marcelle, for instance, Justine or Maria,[1] were at the same time obsessed by fixed ideas, generally latent, and we wondered what influence these two phenomena might have one upon the other. The study of a patient extremely remarkable from this point of view, whom we have already described under the name of Mme. D.,[2] cut short our hesitations. We shall sum up these researches in a few words to complete an important observation. Mme. D., after nine months' illness, still forgot all recent events a few minutes after they had occurred. On the other hand, she pretended, when questioned on this point, to be troubled by no dream, by no idea, and that her mind, except its lack of memory, was as free as it was in the past. We wanted to assure ourselves of this detail and ascertain if really Mme. D. had, unlike the other patients, this continuous amnesia without fixed ideas. We were not long establishing, in her case, obsessions of the gravest sort, unknown to herself, which, nevertheless, disturbed completely the cerebral function. These fixed

[1] *L'amnésie continue*, Communication au Congrès de psychologie experimentale de Londres, August 1, 1892; *Revue générale des sciences*, 1893 p. 167.

[2] *Stigmates mentaux de l'hystérie*, 1892, p. 94.

ideas, as we have already stated, manifested themselves during the crisis, during the somnambulism, and by subconscious acts during waking hours.

How shall we determine the influence of these fixed ideas upon the amnesia itself? By trying to suppress them and examining what would then become of the memory. The direct suggestions—that is to say, the suggestions bearing directly upon the memory—made whether she was awake or during somnambulism, had scarcely sufficed to retain a few words in her memory. The personal and conscious recollections of Mme. D. stopped always on the 14th of July, 1891. Let us see the effect of an indirect therapeutic measure, bearing no longer on the memory, but on the fixed idea, which we suppose to be the important thing. We do not relate how we tried to struggle against the subconscious fixed idea; these are studies outside our subject. At any rate, in a few days, we had modified that fixed idea. The patient still dreamed, but the man who appeared to her scared her very much less now, for he was transformed. He had taken my own face, and, instead of his terrifying phrase, the following: "Madame D., prepare a bed, for I wish to sleep at your house at C." This modification of the hallucination was difficult, but it had an unexpected result. Mme. D., quite awake and conscious, had vague remembrances of her past; she could say spontaneously: "It is a fright that has made me ill; I received bad news." In a few days she recovered the remembrance of the months of July, August, and September—that is, of the oldest periods over which the amnesia extended. At the same time the recollections of the present lasted longer; a quarter of an hour, then an hour, then half a day, then a whole day. It is impossible here to study this treatment and the difficulties it presented. We would remark only that with this patient, and with all others, indeed, there could be established a close connection

between continuous amnesia and fixed ideas. When the latter waned, memory improved; when the fixed ideas again were predominant, which, unfortunately, was but too frequent, the continued amnesia became completely restored. These new stigmata may, then, as the first, be an indirect consequence of the existence of fixed ideas.

How shall we interpret facts of this kind? Very simply, if we but remember what we have supposed while studying stigmata. They were for us nothing more than the manifestation of a great absence of mind; of the narrowing of the field of consciousness incapable of holding all the psychological phenomena. Now, fixed ideas, it will be conceded, are one of the great causes of distraction. It is very evident, even in the case of the normal man, that a mind possessed by a persistent thought is less apt to perceive new sensations and images. With hystericals, whose power of thought and perception is already reduced, a fixed idea will be still more in the way, for it absorbs what little attention the subject has to dispose of, and leaves him more absent-minded, more anæsthetic and amnesic than before.

Let us add that these fixed ideas often deprive the patients of sleep, which is by no means insignificant in maladies caused by the enfeeblement of the psychological synthesis. "Memory," said the physiologist, M. Lesage, of Geneva,[1] "is the intellectual faculty which the want of sleep most affects." Let us also add that fixed ideas, like suggestions, are encroaching in character, that they seem to seize and attract certain sensations and certain images taken from the normal consciousness, and we shall understand how they increase the stigmata of hysteria. This influence of fixed ideas may be considered as a verification of the hypotheses which we have presented on the nature of stigmata. The particular

[1] Quoted in the notes of the translation of Dugald Stewart, by Prévost, Genève, 1808, ii., p. 450.

form which this weakening of perception takes, according to the case, we cannot explain. We shall remark only that the general effect of fixed ideas among the patients is about the same with all. At the moment when the fixed idea develops more or less subconsciously, all become abulic, anæsthetic, amnesic. Mme. D. is absolutely anæsthetic during the dreams we have described, and Maria becomes amnesic when she thinks of ether. But, besides this general effect, there is a special localisation of the weakness of perception of the motor images, of the images of remembrance, or of the sensations, which is the reason that Marcelle is generally more abulic, Mme. D. more amnesic, and Maria more anæsthetic. These differences are due to particular conditions which we cannot always explain.

CONCLUSION

"Many conditions of hysteria," said M. Charcot formerly, "are accidents of a psychological order, and are due to the patient's thoughts." This idea has been adopted and repeated by most authors.

We have endeavoured to confirm these hypotheses by analysing the mental state of the patients who presented hysterical disorders, showing that the fixed ideas were sometimes misunderstood because they were concealed, but that they always played a principal part. Finally, we have shown that such phenomena intervened even in hysterical stigmata, and that they produced them in an indirect manner by diminishing the force of personal perception. Before studying the laws of these fixed ideas and the conditions of their formation, we must examine one other of their effects, one of their most remarkable consequences, the hysterical crisis. For the present we shall be content with studying their frequency and their importance.

CHAPTER III

ATTACKS

"HYSTERICALS," M. Briquet used to say, "are liable to be seized from time to time with special and serious conditions, which appear of a sudden, and usually, after a short duration, disappear as quickly as they came. This gathering of disorders is what is called an attack of hysteria."[1] The hysterical accidents, which were the subject of the preceding chapter, were generally of moderate intensity. They did not lessen the consciousness of the patient to the degree of suppressing it altogether; the accidents were durable and were prolonged without great modification for a considerable time, but once over, they might disappear for a very long time. We call *attacks* accidents, or rather groups systems of accidents which have in a way contrary characteristics; they are acute and often affect the whole mind to the extent of destroying the consciousness the patient has of his own personality. They are of short duration and, unless there be transformations, they do not last beyond a few hours. Lastly, they are *periodical*, and manifest a very decided tendency to return regularly from time to time with the same characteristics.

Attacks are one of the best-known phenomena in hysteria. They have always attracted attention by their strange and sometimes fearful character; they are con-

[1] Briquet, *op. cit.*, p. 327.

sidered in the light of diabolical possessions, as some terrible accidents capable of putting the life of the subject in danger. Later, we learned to distinguish hysterical attacks, properly so called, from convulsions due to a cerebral lesion or to epilepsy, and it was seen that this attack was seldom very dangerous in itself, at least in regard to the life of the subject.[1] M. Pitres studied carefully these difficult diagnoses,[2] upon which we need not insist in this work. We shall remark only that the psychological phenomena play a more considerable part in the hysterical attack than in the other forms of convulsive seizure.

Attacks of hysteria are also remarkable for their frequency. M. Briquet remarked, however, that they were not altogether necessary to determine the case, and that nearly half of the patients were hysterical without attacks.[3] Perhaps he overlooks certain forms, not well known, though quite frequent, of attacks of which we shall have to speak. M. Pitres's estimate of sixty-three per cent. of hystericals who are subject to attacks, appears to us more correct.[4] The patients who do not present any phenomenon analogous to the attack seem to us rather rare, and it is necessary to know this accident well in order to understand the nature of hysteria.

Unfortunately, the attack is an extremely complex phenomenon, or rather it is an ensemble, a system of phenomena very varied and difficult to analyse. Therefore, we must again repeat here what we have often said. We do not in any way pretend to describe all the phenomena of the attack by analysing the psychological phenomena it presents. On the contrary, we maintain that there are in an attack of hysteria a number of phenomena purely physiological, very curious, and insufficiently known. Many a time there may be observed not

[1] Briquet, *op. cit.*, p. 383 ; Charcot, *op. cit.*, i., p. 382.
[2] Pitres, *op. cit.*, i., p. 230.
[3] Briquet, *op. cit.*, p. 347.
[4] Pitres, *op. cit.*, i., p. 207.

only modifications of the respiration, which may be accelerated or reduced, but also the most striking disturbances of the circulation. Sometimes vascular organs swell, the thyroid body hardens, and shows, either on one side only or on both sides, visible pulsations. Erythematous patches with very distinct border appear on the chest and limbs; the menstrual flow is modified, checked, or restored, etc. One may observe disturbances in the innervation of the sphincters, the involuntary emission of urine, which we have twice established in cases of incontestable hysteria, and also troubles of all sorts in the secretions.

A patient, Od., as a result of an emotion, principally anger, may react in three different ways; either she has immediately a convulsive attack with delirium, in which she feels, after a few minutes, a profuse menstrual flow reappear, whatever the time of the emotion; or again, if these two manifestations of the emotion do not take place, she experiences great uneasiness, and, after a few hours, she is covered from head to foot with a fine papular eruption, the papules the size of a pin's head, which do not itch and which disappear towards evening. Whether these physiological facts be dependent upon psychological or cerebral phenomena,—as it very often happens, we think,—or whether they are independent of them, they certainly exist during the attack. We intend, in this work, to examine especially the mental phenomena of hysteria. They are the most evident and the most numerous; perhaps it is even indispensable to know them well before attempting the more complex study of the physiology of hysteria.

The attacks being, at least at the beginning, very diverse, we shall first describe separately the principal varieties with the more important psychological phenomena which characterise them; then, in a final paragraph, bring together as far as possible the most general views

which to-day may be expressed concerning psychological automatism in fixed ideas and in attacks.

§ 1—EMOTIONAL ATTACK, OR BRIQUET'S ATTACK

We purpose giving the name of M. Briquet to the more common of hysterical attacks, the one designated under the different names of slight hysterical attacks or nervous crises. It is an ensemble of sensory and motor phenomena not very complex at first. The patients complain of a variety of pains, put their hands to their throats as if they were suffocating, "as if some big ball or some big chestnut, as they call it sometimes, were rising in their throat and choking them." These diverse sensations are the forerunners, the aura of the attack; then they fall on the ground, lose consciousness generally, and are seized with extraordinary movements; after a little while, they finally wake up in a quarter of an hour or so, generally crying and groaning. It is difficult to give a precise description of this slight nervous crisis, as it varies in different patients. To us, however, it seems to assume two particular forms, the convulsive and the syncopal. The first attack, very well described by M. Pitres,[1] is especially characterised by inco-ordinate movements, which follow hard upon the aura, when the patient has fallen down and lost consciousness. They are tonic contractions which produce almost always a very particular attitude justly considered as characteristic. The patients stiffen themselves, then seemingly try still more to extend themselves by throwing the head back, bending their back, and raising the belly; they no longer press on the bed except with the head and the feet; they make "a bridge," according to the common expression. Then, after these general contractures, or mixed with them, we have irregular convulsions without there being repeated

[1] Pitres, *op. cit.*, p. 211.

any very definite movement. The head moves about from one side to the other, the eyes open and close; they make grimaces. Now the sufferers will clench their teeth, yet without biting their tongue; now again they will open the mouth and utter screams in various tones. The arms move in every direction, strike at haphazard the surrounding objects, and the patient's own chest, the fists clench and unclench alternately, the legs are stretched, then flexed—in short, all sorts of movement occur without any great significance. During this time, the breathing is loud, irregular, the heart-beats bounding, the face congested, without, however, becoming purple, as in epileptic attacks.

A calm comes usually very suddenly, the patients remain a few seconds as if stunned; they rub their eyes, look with astonishment at the surrounding persons and ask what has happened. When the attack has been a short one, they immediately look to the disorder of their clothing and, without delay, take up again their habitual occupations. If, on the contrary, the convulsions have been violent and long, they experience a feeling of great lassitude which obliges them to rest for several hours; they do not fall, however, into that stertorous sleep which ordinarily succeeds epileptic fits.[1]

The second variety, the syncopal form, is less frequent. After an aura, similar to the preceding but sometimes shorter, the patients feel themselves growing weak, they faint, according to the common and correct expression.[2] Th. faints every moment one wishes to shake her, to make her eat, etc. The patients have no convulsions, they remain motionless, the eyes half-closed, the head hanging loose, the limbs flaccid. At most, a few little contractions may be noticed in the hands, which remain closed or make a few rhythmic movements. These slight movements, when they are noticeable, help in the diagnosis. In these attacks the face is generally pale, and not con-

[1] Pitres, *op. cit.*, i., p. 213.

[2] Pitres, *op. cit.*, ii., p. 243.

gested; the breathing is retarded. In the cases we have been able to observe, the beating of the heart remains normal. Generally, this state is of short duration; it sometimes ends in a sleep more or less prolonged. There is no need to insist here on other clinical varieties, which are very numerous.

These are conditions which, at first sight, seem purely physical, and yet it is easy to prove that psychological phenomena play a certain rôle in their formation and even in their reproduction. "The first attack," says M. Pitres, "comes almost always after a strong moral emotion."[1] Perhaps, if we knew better the beginning of the attacks among all patients, we might say that it is always so. Examples were easy to furnish. We shall point out only a few to show what sort of emotion is generally followed by hysterical attacks. We shall first indicate such crises as are caused by pain. Sometimes, though rarely, it is a physical pain. A man, Lah., has been suffering for two years with a true facial neuralgia, a case diagnosed before its hysterical symptoms. When the neuralgia became very bad, he would howl, gnash his teeth, roll on his bed. Recently he lost consciousness and had a real attack of hysteria, which now repeats itself and is accompanied by the classical stigmata. Oftener still, the provocative pain is of a moral character. Dp. had her first attack after the death of her husband; D. after the death of her mother, etc. Annoyance and anger provoke still more attacks. Déc. had an attack from having been reprimanded by her mother; Doin. after a quarrel with her husband; Lyn., Zelm., and many others, had attacks from a violent passion. In short, surprise, fear, terror, are common causes of attacks. Salz. had a crisis from witnessing an epileptic fit in the street; X. from seeing a man fall out of a window; Baun. from setting her dress afire with a petroleum lamp;

[1] Pitres, *op. cit.*, i., p. 208.

Genp. from having discovered the kitchen afire; Pau. from having been pursued by an unknown person at the time of her menses; Gal. from finding a thief concealed in the cellar, etc., etc. Often it is a complex accident which provokes both pain and terror. Alz. was crushed by an elevator which fell on him. He had his left shoulder wounded, and has since had formidable attacks. It is useless to multiply these examples indefinitely; we shall observe only that the syncopal attacks are oftener the result of terrors rather than of other emotions. But this emotion established in the first attack seems to have come to an end. The patients are quieted now; they see no longer conflagrations, discover no more thieves in the cellar. Why do they continue having attacks? We think that we can prove that at each new attack the origginal emotion takes place again. In some cases we can establish this fact by examining the patient's attitude and movements during the convulsive attack itself. Celestine, Zelm., still have, it is true, attacks of anger. Their eyes are flaming, their faces threatening, their fists clenched and ready to strike. The second attack, moreover, emphasises the condition. In the midst of her convulsions she says: "Don't touch me, or I 'll strike." Pau., on her side, is all in a tremble; she hides her face in her hands. Gal. turns away with horror and runs away, crying: "Oh! mother, that man!" They are but single exclamations, for we do not number in this category the patients who really talk in their attacks. The attitude, the gesture, are here significant and recall often the nature of the original emotion: pain, anger, or terror.

When the slight convulsive attack is not significant in itself, let us study the psychological phenomena which yet manifest themselves during the preceding period, during the aura. Many authors, and M. Pitres in particular,[1] have insisted on the existence of a psychic aura

[1] Pitres, *op. cit.*, i., p. 211.

which, in the attack, plays as important a rôle as the sensory and abdominal aura, as the ball rising in the throat. The patients' disposition changes some time before the attack. They are troubled and excited, and the emotion they experience, more or less vaguely, is always the same for each patient. It is always in a line with the original emotion. Celestine is angry "without knowing why." Pau. is afraid, "as if some misfortune were threatening her." But we would insist on the description of an aura which we have frequently studied and which is very characteristic. A patient often described in this work, Bertha, is a very gentle and affectionte young girl. She likes company, jokes and laughs, usually, without getting angry. At certain moments, generally in the morning, her bearing changes. She replies curtly to your remarks, and seems to take everything said to her in ill part; then she becomes excited, picks up some word said to her, complains of it, finds it rude, and sees a sarcastic intention in it. Now you hear her talking alone to herself, louder and louder. She gives vent to complaints which, at first, have respect to people present, and then becomes more and more general. Now, she pays no longer attention to anyone and launches her epithets at random. They are phrases ever the same, absolutely stereotyped, which she repeats regularly under the same circumstances, which even at this moment she writes, for she takes sometimes a notion to write a letter.

I know all these people very well; they just seem to be interested in me, but they are full of contempt for me. . . . I know about the selfishness, the perfidy, the lies of this horrible world. . . . In this human medley of bitter words, discordant cries, lies, calumnies. . . . To hate one's neighbour, hate all there is. . . . To-morrow perhaps all those I hate will suffer: oh! how well I am going to sleep on this hope. . . . There is nothing nobler than hatred; it needs only to be shared with someone; it knows no

infidelity. . . . On the bare vault of the heavens I see the terrible and consoling face of him who delivers everyone from all this slavery, from all these ills, Death . . . etc.

These declamations, always the same, last over an hour, when the patient becomes more and more excited, mixes cries and howls with her phrases, rolls on the floor, and, although she seems to lose consciousness, still continues in the midst of her convulsions the same screams and the same curses.

In such an attack there are two phenomena to distinguish: the curses and the screams at the beginning, which, by their regularity and their systematisation, form an emotive state somewhat special, yet very clear; and the convulsive movements at the end. Of these two phenomena, which one is clinically the more important, and which one determines the other ? It is, to our mind, the persistency and the automatic reproduction of the emotive state. This is, in truth, the malady of this young girl, a mental malady which grew, little by little, in consequence of frightful misfortunes. The convulsions are but an incident, a passing, not a necessary, manifestation of the emotive state. The psychical phenomena of the aura, which, with some patients, are so distinctly expressed, show us the repetition of the original emotion.

But the difficulties are still greater when we examine other patients who have not so prolonged a psychical aura, nor so clear a one. We may also, with some, discover the rôle of emotion by examining the nature of the causes which bring back the attack. George, for instance, is seized instantly, almost without warning, but we observe that he was seized because he looked at the fire in the stove. You can provoke the attack by showing him a lighted match or only some red paper, and in the attack which supervenes he tries to run away, crying, " Fire," and calls for the firemen. Have we not the

right to say that an association of ideas has induced, at the sight of a little flame, the reproduction of the emotion he experienced in seeing the kitchen on fire ? If you touch Alz.'s shoulder, at the place where he was wounded by the elevator, you provoke an attack in which he constantly makes terrified gestures as if about to be crushed. We have already demonstrated the nature of these hyperæsthetic points, the touching of which provokes determinative sensations capable of awakening a former state of emotion. They become hysterogenous when the emotive state which they awaken is accompanied with convulsions.

Finally, many patients have attacks the psychological character of which is still less distinct; the emotion is not in any way expressed by the patient, who seems even to be entirely ignorant of it. Before denying its existence we must find out if the fixed idea did not exist in a subconscious manner, as happens so frequently with hystericals. For example, certain attacks, developed some time during the night, " are caused by frightful dreams having relation to the moral shock which determined the patient's first attack." [1] The patient awakes without remembrance of the dream which provoked the attack; yet this dream is real; it even plays in the attack the most important rôle and its existence can be proved by either the words which the subject expresses in his sleep or the account he gives of it in his somnambulic state. It is the same regarding the attacks that take place in the daytime; they also are the consequence, the manifestation of a dream, but the subject dreams without knowing it, without being able to render a conscious account of it. We can prove it only by a study of subconscious phenomena. We would recall, in regard to this, an observation we published in 1886. Lucy had violent attacks, the nature of which she could in no wise explain when

[1] Féré, *Pathologie des émotions*, 1892, p. 151.

awake. She suffered, before the attack, from vague sensations, a general state of flurry. During a deep somnambulism, she relates in detail the hallucinations which come uppermost during the crisis and which provoke terror: she sees a number of men concealed behind the curtains of her room. This image reproduces a real fact which occurred several years ago and of which she has a minute remembrance in the somnambulic state.[1] Still more, if you succeed in inducing automatic writing during the period of the aura, her hand writes, constantly, "I am afraid; I am afraid," while, when awake, Lucy declares that she is not afraid, and says she does not know what we mean when we question her on this point.[2] X. likewise does not explain her crises except when put into a somnambulic state. She has an attack of genital aura for which she cannot account when awake. At once, when in the somnambulic state, she remembers very well that she still thinks of her husband and the sufferings she underwent at the moment of the conjugal act. (Her husband infected her with blennorrhea on the evening of her marriage.) We shall see many examples of this kind when we come to study more complicated attacks than the simple emotional crisis.

We may, then, conclude with this first category of attacks. The explanation of it has already been given in a remarkable way by M. Briquet, and this is why we have described this particular kind of attacks under his name.

An attack of simple hysteria, he says, is only the exact repetition of the disturbances by which the strong and painful moral impressions manifest themselves.[3] . . . I choose, for an example, what happens to a woman somewhat impressionable who experiences a quick and lively emotion. She instantly feels a constriction at the epigastrium; experiences

[1] *Revue philosophique*, 1886, ii., p. 590, and *Autom. psych.*, 1889, p. 87.

[2] "Les actes inconscients et le dédoublement de la personalité," *Revue philosophique*, 1886, ii., p. 590.

[3] Briquet, *Hystérie*, p. 397.

oppression, her heart palpitates, something rises in her throat and chokes her; in short, she feels in all her limbs a discomfort which causes them in a way to drop; or else it is an agitation, a necessity for movement, which causes a contraction of the muscles. This is indeed the exact model of the most common hysterical accident, of the most ordinary hysterical spasm.'

M. Pitres adopts, in general, the preceding opinions, when he says that the symptoms of the crisis are the same as those of the emotion.[2] But he is in too great haste, we think, in translating these psychological facts, still vague as yet, into anatomical language, speaking of an encephalic centre of affective passions.

MM. Breuer and Freud, more recently, with several German authors, speak in the same way, namely, that the phenomena of the hysterical attack may in part be traced to the emotional reactions that accompany a remembrance.[3]

Perhaps we might give precision to this notion by recalling the little we know of the nature of emotion: "Emotion is not a simple phenomenon, a manifestation of the faculty of sensibility, as was formerly said; it is an ensemble of a great number of elementary phenomena, a state of complex consciousness."[4] A few of the elements which enter into this state are known: peripheric or internal sensations, images, remembrances, etc.; but how many are still unknown! We cannot exactly explain why such or such an attack has a convulsive form, why another a syncopal form; why a patient blushes, another grows pale; we suppose, without being able properly to demonstrate it, that the tension of all the muscles produces the arc of a circle through predominance of the muscles of the dorsal region, but we cannot say why such or such a movement takes place, why such or such

[1] Briquet, *op. cit.*, p. 4.
[2] Pitres, *op. cit.*, i., p. 266.
[3] Breuer et Freud, *op. cit.*, p. 10.
[4] *Les stigmates mentaux*, p. 214; *Autom. psych.*, p. 215.

attitude. This ignorance does not exactly bear upon the knowledge of hysteria, but on the knowledge of the emotions and their laws. What is important to know, in regard to hysteria, is that in the attack there is an emotion and that it is due to the reproduction of a dream. This is what is properly hysterical, and which explains, if not the details, at least the ensemble of the phenomenon.

M. Briquet has already observed that the attacks are the manifestation of emotions, but "exaggerated and perverted emotions."[1] Let us try to understand this restriction. One thing may at first surprise us, namely, the great similarity of the different hysterical attacks, although the original emotions have, in reality, been very unlike each other. We might say that the emotions, when they are violent, are more or less alike—that joy, as well as grief, brings tears; but we think it better to recall a fact already often pointed out in regard to subconscious phenomena, namely, that these phenomena are in the beginning clear and defined, but they are overpowering and lose their precision as they advance. A subconscious phenomenon provokes in the beginning a partial paralysis, a systematised contracture, and soon a general paralysis or contracture. It is the same with the attack. Celestine, in her childhood, had a very decided temper; she struck any person who attempted to rule her; that temper decreased. Since the age of thirteen her fits of temper are less determined, and it may be remarked that she insults people at random. She will strike even a mattress, fancying it "was laughing at her." At sixteen, the attack has no longer a distinct form of anger, except right at the beginning. The limbs move about in so inco-ordinate a manner that it is no longer possible in these convulsions to distinguish the acts of anger. When the emotions become thus overpowering, it is clear that they become at last all confounded.

[1] Briquet, *op. cit.*, p. 330.

Another characteristic of emotional hysteria is its isolation in the mind of the subject. The dream that calls them forth is reproduced in a subconscious manner, without the subject's being able to establish any opposition between the sensations and the present ideas and this besetting remembrance. When the dream has invaded the mind, it has reduced the perception of present things. In both cases, the emotion develops apart, without being in any way counteracted. It is natural that it should take a particular form, different from that of normal emotions.

If we take note of these characteristics, of our ignorance concerning the laws which regulate, not only morbid emotions, but also normal ones, we must admit, with M. Briquet, the existence of emotional attacks due to the reproduction of a dream, a fixed idea.

§ 2—TIC ATTACKS—CLOWNISM

The various accidents which can affect motion, and, especially, the tics, the importance of which we have seen among hystericals, instead of presenting themselves isolated and in a continuous manner during the waking hours of the patient, may converge, condense in a way for a short time, and more or less obnubilate the consciousness and constitute a variety of attacks.

M. Briquet had already observed that tics, whatever their kind, were regularly reproduced at every attack.[1] "It is not jugglery," he said, describing one particularly queer movement; "all was done under the impulsion of the brain in a state of perturbation."[2] Many authors have since described these attacks as "juggleries," when they describe patients climbing, dancing, etc., and such contortions as call up those of clowns, which for this reason have been justly designated under the name of

[1] Briquet, *op. cit.*, p. 365.

[2] *Ibid*, *op. cit.*, p. 375.

"clownism."[1] Although they may exist with all patients, attacks of this sort are especially frequent in infancy. M. Jolly, in his study on hysteria in children, describes them repeatedly: "This child, eleven years old, shows such skill in tumbling and climbing that it might have exhibited at a circus."[2]

We cannot dwell at length on descriptions of this sort. A few examples may suffice. We shall select the least common cases, tics of this kind among adults. L. weeps and groans because she has lost her husband. This is quite natural; but as she is an hysterical, she does not groan in the ordinary way. She groans in attacks. From time to time, repeatedly during the day, she thinks of her misfortune and utters a slight whine. This is enough; she can no longer stop, and she utters for two hours sharp and monotonous howls that disturb all the neighbours. Then she stops and goes off for a walk as if nothing had happened, and is ready to begin again in a few hours. Renée's case is a résumé of all the others. She feels uncomfortable, is choking; then, from the least pretext,—a noise, a touch, especially the latter,—she screams and the scene begins. She dances and writhes, twisting her belly bayadere-fashion, then rolls on the floor, executing very characteristic pelvic movements. She jumps next upon her feet, raises her right arm, and leans her head against it, keeping a fixed posture, or else she kneels down as if to pray. All this is mixed up with cries, a wild, harsh shriek, something which, for want of a better comparison, we likened to the camel's cry, then to the cat's mewing, the dog's bark, or else she imitates little children, makes up words: "Zozo, nounu, patapan, etc." With all this she does not forget rude remarks and insults, of which she has a large supply. This lasts about

[1] Paul Richer, *Hystéro-épilepsie*, 1885, p. 201.

[2] Jolly, "Ueber Hysterie bei Kindern," Sonderabdrück aus der *Berliner Klin., Wochenschrift*, 1892, No. 34, extrait p. 7.

an hour; then she calms down and her tone and language are entirely changed.

The authors who have described this kind of attack have almost always made the same general remark—to wit, that the patients, although in a very particular intellectual state, never entirely lose consciousness. "The children," says M. Jolly, "move about as in a dream, as if they played a part; but they preserve a certain perception of reality, and they recognise and repulse people they do not wish to draw near."[1] We have also observed that these patients preserved not only their consciousness, but even the remembrance, and a quite exact remembrance, of their attack. Renée, in particular, was very curious on this point. At the most violent moment of the attack, she could interrupt her tantrums and abuse, and say to us, in an altogether proper tone, "I beg of you, do stay; it will be over in a minute," and right upon this she would begin to abuse us anew. This has naturally given place to the charge of simulation. The patients themselves are taken in by it, and Renée said once, crying: "People must think that I do it on purpose; it makes me very miserable, for it is not so; I have a horror of such things." Where is the truth? This half-consciousness is undoubtedly due to the fact that automatic phenomena are very simple. Just a few motions,—always the same,—a few cries, and none of those great complex emotions, those vast dreams which invade the whole mind. The patient is, so to say, the spectator of his gesticulations just as the medium looks at his hand writing involuntarily.

The point here again is, in fact, fixed ideas developing themselves outside the patients' will. All these tics have an origin, and reproduce an incident of their past life. Renée mews like the little cat which came one day innocently to lick the end of her fingers; she barks like

[1] Jolly, *op. cit.*, p. 5.

her father's dog,—" a big, ugly dog, which everybody fondled at home and which gave her the horrors." She imitates the voice of a little idiot, the boy of the pastry-cook, whom she saw in the streets; when she raises her arm straight up it is to take the attitude of " Truth," in M. Jules Lefevre's picture, which she saw in her room. We formerly said [1] that we had tried to find examples of hystericals posing in their crises as in pictures, and could not find any. We were fortunate to obtain this observation in M. Charcot's service. This curious attitude was already assumed by Renée in her crises long before she came to the hospital. It is easy to find an origin of this kind for all her strange movements.

The subconscious character is also quite evident. The patients establish their movements, and can neither stop them, nor modify them, nor even foresee them. We have noticed that Renée catches every instant a new tic and repeats in her attacks either an expression or a gesture of one of the patients of the room. We have tried ourselves to suggest gestures to her, tics to take the place of the old ones and modify them. It was at first quite impossible to succced. We could not by turning to her directly, but succeeded quite well by employing the method we have often described —namely, suggestion by means of distraction. The suggestion had to take place without her suspecting it, while she talked with other people. We thus whispered into her ear the word " baby," which she had never said and which she has since repeated in all her attacks. We made her thus modify her various movements, etc. The character of such suggestions, which have been studied experimentally, permits us to understand the nature of the attacks which resemble them.

It is useless to dwell any longer on these crises of tics, having already studied tics in a general way in the preced-

[1] *Autom. psych.*, p. 52.

ing chapter. They are of the same nature here, except that they have accumulated in a brief space and diminish the consciousness of the patients to a greater degree.

§ 3—ATTACKS OF FIXED IDEAS—ECSTASIES

We have come to a third category of attacks, in which emotional phenomena and convulsive movements are reduced to a minimum. The patients remain, so to say, immovable; sometimes they are completely inert, and seem to have as little thought as motion. However, the study we made some years ago of a patient, Marcelle,[1] interesting in many respects, permits us to recognise that the mind of the subject was far from being wholly inactive during these attacks, but that it was, on the contrary, obsessed by a number of psychological phenomena of an intellectual rather than an emotional order. We have since been able to study examples of these attacks of ideas, which are, we think, very important in hysteria for their frequency and pathological consequences.

Marcelle—as we said in our preceding study—is not always in the same mood when approached; at one time she speaks well, expresses herself cheerfully; at another she is sombre and refuses to say a word. When we approach her at one of those bad moments, she does not seem to be aware of our presence; she looks fixedly down without moving her eyes; if we give her a good shake, she does not resist, or perhaps utters an angry growl. The next day, we find her in a very good humour; and quite disposed to talk with us. "What was the matter with you yesterday?" we ask her. "What had you against us to receive us so badly?"—"Yesterday? You did not come."—"Indeed we did; we stayed half an hour with you."—"I did not see you."—"What were you thinking of,

[1] "Étude sur un cas d'aboulie et d'idées fixes," *Revue philosophique*, 1891, i., p. 271.

pray?" — "I don't know . . ." These words already hint at an important state which leaves no remembrance, — a slight disturbance in the consciousness. We saw by chance one day a curious attack of the same kind begin and end right before us. Marcelle was talking with considerable animation; she showed in her physiognomy sufficient mobility, she moved her eyes hither and thither, although, according to her bad habit, she would not look us in the eye. All at once, without any appreciable preliminaries, she stops talking and remains absolutely immovable, her face a fixed stare; she does not seem to hear us any longer; does not resist when we pinch her, keeps her eyes wide open without moving them; in short, she allows for some time her arms to stay uplifted whichever way we put them, as in a semicataleptic state. This kind of attack did not last more than a quarter of an hour; the patient uttered a few sighs, tears came into her eyes, then, as if by an effort to control herself, she began again to speak with us as if nothing had happened. When we question her, she answers: "It is nothing; it is my ideas that pass . . . it is like a passing cloud." We found the expression rather picturesque, and in our description of this person we retained the word "cloud" to designate the crisis, and tried to understand what took place in her mind while the cloud was passing.

Before entering upon this study we must observe that the preceding phenomena are found in many patients. It is not rare to meet motionless hystericals, eyes fixed, generally open or half closed, sometimes quite closed. It is rare to obtain any answer from them. Sometimes they appear to waken of a sudden when you shake them; sometimes, again, they cannot be awakened, and come out of this state spontaneously after a certain lapse of time. With some, this kind of sleep is combined with convulsive attacks, which either precede them, or follow them, or take place, as with Bertha, in the interval of the emotional attacks, and in some sort independently. With others, again, these states of immobility are the only

attacks to be established, and constitute the principal hysterical condition.

Among the patients we have described in this work we shall note Justine, whom her husband found sometimes standing, eyes fixed and mouth half open, and by whom he could not make himself heard; but we shall dwell on the "fixities" of Maria, which were very remarkable, and to which we have already made allusion.[1] It is thus the patient herself designated one of her most frequent attacks. Here is an example: Maria is coming down with other patients to attend mass in the chapel; she appears all right and behaves quite reasonably. During the mass her neighbour notices that she has for some time been entirely immovable, that her eyes look fixed, and that she is pale. She speaks to her in vain, and then decides to touch her and push her a little. Under this impulse, Maria falls from the chair on which she was kneeling, and, without being wakened by the shock, remains lying on the floor like an inert mass. She is picked up and carried out without becoming aware of her condition. When we examine her, her eyes are still half open, and look still to the left as they did in the chapel. At times some tears steal through them with the least motion of the eyelids; her limbs are supple and fall back flaccid. The anæsthesia is absolute; no kind of excitation induces a reaction. The patellar reflexes are preserved, but not the palpebral ones. After an hour or so the patient has a slight chill, utters a deep sigh, and looks all around: "Now! how is it I am in my bed? What has happened to me?" When questioned, all she knows is that she went to the chapel, that she had someone by her side, that she looked at all the people around her: and this is all she can tell.

In other circumstances, Maria stops in the midst of a conversation, "looking fixedly" at a bed or a chair.

[1] *Stigmates mentaux*, p. 140.

When present at the beginning of the attack, one can wake her by a strong sensory impression—the jet of a siphon in her face, for example. If the attack is allowed to develop for a few minutes she can no longer be brought out of it. She will not come out of it spontaneously until after an hour or two. Such is the phenomenon in its general aspect. We do not speak here of the varied phases it may present in detail.

Our preceding studies have taught us that we must not be satisfied with the examination of this outer form of the phenomenon, and that one can, by various processes, penetrate farther into the consciousness of the subject.

This study of the cloud—we said, speaking of Marcelle—has presented great difficulties; for during the crisis she does not answer, and after the crisis she seems to have forgotten all. However, little by little, we were able to gather a few facts by diverse methods: 1st. In certain very slight and transitory paroxysms we succeeded in getting from her a few words and some signs. 2d. At the end of the paroxysm, in the transitory period often characterised by tears, she has sufficient remembrances to give a few indications of them, and forgets them the next moment. 3d. In putting her deeply to sleep we succeed in reproducing several characteristics of the states analogous to the cloud; in which states, however, she remains *en rapport* with us and can answer us. 4th. Lastly, the automatic writing which, as we have already said, is a faculty of this subject, has furnished us a variety of information which we could not have obtained orally by any other process.[1]

In regard to the other patients, and in particular to Maria, we could employ only the last two processes, which are the most efficient. Somnambulism, as we know, brings back the remembrance of certain attacks, and with this patient this return of the memory was

[1] *Aboulie et idées fixes*, p. 272.

very regular. The automatic writing, obtained while awake by the process of distraction, allowed us also to obtain a manifestation of these subconscious phenomena.

What have we learned by these processes? That attacks of this sort are a kind of "crises of ideas," so to speak. The patients are not without consciousness; they are not without thought; on the contrary, they are absorbed by an obsessing thought which fills their small field of consciousness. Their apparent insensibility is an anæsthesia through distraction due to the ideas which encumber their feeble thought.

These ideas, which appear thus during the attack, are most varied, but they have, in common, a few characteristics which we must first point out. They present themselves almost always under the form of images, extremely vivid and complex, which are not contradicted by anything and which give to the patient the complete illusion of reality.

Let us review some of these hallucinations, beginning with the least frequent. Marcelle has never had, we think, any hallucination concerning taste, smell, or touch. She has sometimes hallucinations about hearing. She tells us that she hears noises, music; sometimes she starts, turns her head in the direction of the noise, and appears to listen; she hears someone call her from afar; but this is a rare occurrence and happens only during very severe attacks.

She has oftener visual hallucinations. She sees black animals move before her; her bed appears to her covered with mice, which she thinks will gnaw her wrist. She sees people pursuing her, who want to kill her; they have terrible faces, and she is in great fear, and yet she cannot move. For several months she has had a crisis of visual hallucinations much more important and characteristic. Some six months ago, during a short absence from the hospital, she witnessed a very painful scene

which made a great impression upon her. Discretion forbids our relating it in detail. Since that event, Marcelle saw in all her cloud-crises this scene exactly reproduced. There are the same scenery, the same personages, the same attitudes—all was exactly repeated, and this poor patient would remain the whole day absorbed in this painful contemplation. Among the other patients Maria had also numerous visual hallucinations during her attacks, particularly an hallucination of this kind which filled out the attack beginning in the chapel and described above. When under somnambulic influence, this is the way she relates what happened:

All this occurred—she says—on account of this simple fellow, a poor infirm patient, so ugly! who was seated in the chapel to my left. I kept looking at him, saying to myself that I had already before seen this frightful face somewhere. I then saw before me the corpse I had looked at so long at the Morgue; it was the same horrible face, swollen up, violet and green; I saw it before me, and could not help looking at it.

In other cases, she fancies or thinks she is in a pharmacy and smells ether.

With all the patients, and with Marcelle in particular, these visual hallucinations form, however, but a small part of the phenomena that occupy the mind during the attack. They generally give place to another category of images, much more frequent and more important. They are verbal images, the images of language, and the crisis is filled with a long inward gabble. These verbal images might be auditive images, and we see no reason for denying the existence of original auditive hallucinations with hystericals, which we have repeatedly even proved.

During these attacks, Marcelle hears someone call her and would even get up at times to answer. Maria heard and recognised her husband's voice. But we must say that these auditive hallucinations are rare. Generally these

verbal hallucinations are the reproduction of kinæsthetic sensations, the same one experiences when speaking oneself. It is a simple inner language repeating monotonously ever the same ideas.

Marcelle pretends, in fact, that, during the cloud, she is told a lot of things. She exaggerates a little. It seemed to us that these frequent inner speeches were but little varied, being insistently repeated, like the deliriums of an hysterical crisis. We establish, first, in these speeches ideas of persecution, a quite important fact with this kind of patients. Marcelle keeps repeating to herself that her mother and everybody else bears her ill-will, that her brothers detest her, and that all the world turns away from her as if she had the plague; everybody is afraid of her, etc. These ideas vary only according to the person she has to do with. Thus, when she first came to the hospital, she was quite disturbed on seeing M. Falret, who certainly does not look unkind, and in all her clouds she kept repeating: "M. Falret, one more to bear me ill-will; one more to bear me ill-will." These ideas of persecution develop after a few months, but very slowly. She would say in her crises: "My mother is not my mother, my brothers are not my brothers; I do not belong to their family . . . they have shut me up to rob me." We must not stop here on the character of these ideas of persecution, to show that they do not present themselves the same way except with the really persecuted. We shall have to come back to this subject in speaking of hysterical deliriums. Let us observe only that such ideas, analogous to those that have been pointed out in the aura of Bertha's emotive attack, are very frequent in these reveries and that they have existed more or less frequently among nearly all the patients. Maria would thus spend hours getting angry with another patient or with her husband, talking about vengeance and suicide. Along with these ideas of

persecution we observe, especially with Marcelle, other ideas of a very great importance. They are in the shape of commands, or simple and rapid prohibitions, which are persistently repeated in her mind. The most important with her are: "You must die . . . die as quick as possible"; or, "Don't eat; you do not need to eat. . . . Don't speak; you have no voice; you are paralysed . . . " etc., commands which she repeats clearly only during the cloudy crises, but which have a great influence on the rest of her life. With patients, impulsive like Maria, possessed with the idea of drinking ether, it may be guessed that commands of this kind had very often relation to the dominant impulse.

But with several other patients we establish a babble much more curious. Maria has become "fixed" looking at her bed. After putting her into the somnambulic state, we asked her what she was thinking of. "It happened to me," she said, "because I looked into the mattress of the bed at a spring-roller. What a funny thing a spring-roller is! How is it made? Never could my poor head understand so much!" Or, again, she becomes "fixed" in regard to a chair, a gas-burner, a tin pot: "To think that there are people able to make tin pots; how do they manage?" Interrogations about things during ecstasies are very frequent with Maria; they go back to infancy. Already, when twelve years old, she would stand transfixed, looking at a tree. Her mother boxed her ears to call her back to reality, but could not get her to relate her dream; it was always forgotten. To-day, put into the somnambulic state, she remembered that she thus dreamed. "How funny that box-wood should be so green! How does the cherry-tree manage to be so tall?" After having studied a patient of this kind we were not surprised to see Bertha question herself, during her attacks, concerning a stove-pipe, thread, a hat, the same as upon great philosophic

problems: "What is life—what means living?" Or to hear that Justine, standing in the middle of her room, with her eyes fixed, was meditating for hours the spelling of some word. We have already seen how the insufficiency of attention prevented hystericals from perceiving things clearly, and called forth surprises and interrogations. We can see now how these questionings may completely fill the small field of their consciousness, be in the way of any other perception, any other recollection, and constitute at last the attack of ideas.

Thanks to somnambulism we are able to recover the ideas which filled the mind, and see how simple and few they are. A few hallucinations, especially visual ones, reproducing an event which has struck the mind of the patients, a few ideas of persecution and suicide, and especially tittle-tattle, interminable questions about things scarcely perceived—that is all that fills the mind during these attacks. M. Briquet spoke of the "serious thoughts"[1] which provoke ecstasy. This is because he had perhaps not been able to determine the nature of these thoughts. We much fear that many ecstatics, among the most revered, have never thought of anything higher than the monotonous interrogations of Marcelle or Maria.

We have yet to point out briefly the principal varieties of this kind of attacks. They may be classed, we think, according to the nature of the outward manifestations which express those fixed ideas. The foregoing patients form the first group; they do not in any way manifest their ideas outwardly; they seem asleep. Some are entirely relaxed; others present a certain degree of contraction, and resume, with a sort of obstinacy, their primitive position when one has tried to modify it. Such attacks have often been described under the name of hysterical sleep.

The very curious patients, those who partly express their dream by their attitude, we will place in a second

[1] Briquet, *op. cit.*, p. 410.

group. M. Paul Richer has carefully described and has even drawn those attacks in which the patients keep their hands folded in prayer, or their arms crosswise,[1] and represent thus by their expression the idea that moves them. The ecstatics who used to take the pose of the Immaculate Conception, or the attitudes represented in the Way to the Cross, or who played completely the scene of Christ's death, belonged to this category.[2] The question here, understand, is as to more or less clear dreams, constituted generally by kinæsthetic images, and capable of determining correspondent movements. The principal factor remains still the reproduction of the dream in a particular psychological state.

Lastly, in a third category, we will class the patients who "speak their dream instead of playing it," according to M. Paul Richer's expression—namely, those who have verbal kinæsthetic images sufficiently clear to be objectified, and to produce a real voice more or less loud which reveals outwardly the patients' thought. The most curious case is that of Josephine L. At every moment of the day she closes her eyes, remains immovable and insensible to any excitation, chatters aloud about anything and everything,—her marriage projects, her intended suicide, the happenings in the ward:

> These doctors! what swine! They have again carried away a poor woman to cut her up . . . *couillons*, idiots . . . if ever I obey you, if I ever again take any of your nasty medicines! . . . I am going to be married; I shall have fine clothes . . . no, I would rather die; I am going to write my will; X. my little friend shall have millions and G. (the ward's clinical clerk), this squirrel-head, this swine, he shall have no more than six cents. . . .

She would go on this way without its being the least possible to enter into conversation with her, and she

[1] Paul Richer, *Grande hystérie*, p. 92. [2] *Autom. psych.*, p. 53.

would wake of herself without remembering anything she had said.

Hysterical deliriums of this kind may be still more complicated. The patients, in the midst of hallucinations of every sort, especially visual hallucinations, brilliant, full of excitement, like those of the alcoholics, will continue a great complicated dream, which they express by attitudes, words, actions of all kinds. Justine's attack may, from this standpoint, be considered perfect. It shows us "the complete development of all the images that can enter into an idea."

Justine is obsessed by the fixed idea of cholera. How does this idea present itself to her during the attack? The patient looks before her and sees—first in a vague sort of way, then very distinctly—two corpses of a greenish blue. She smells an odour of putrefaction, hears groans and cries; she feels within herself, in her stomach, a voice saying to her: "The cholera; thou hast it, thou art going to die of cholera!" This voice is soon realised outwardly, and the patient cries: "Cholera, cholera!" She feels the cold invading her, she stiffens her limbs as in contracture, throws up her food, and even at certain moments cannot avoid evacuations. Is not the picture complete? is it not an idea of which all the elements have developed, as we have seen, into the most perfect suggestions?

From the first degree of the reverie to the greatest deliriums, the attacks have presented the same characteristic: they are always ideas that have taken possession of the mind of the subject so far even as to suppress every other thought and every other perception.

§ 4—COMPLETE ATTACK—CHARCOT'S ATTACK

The attacks we have just described have been selected, among other observations, because of their relative

simplicity. Each one of them was constituted almost exclusively from a psychological point of view, either of emotional phenomena, or of images of movement, or of dreams. This is a rare thing. Generally the different kinds of attack and the diverse psychological phenomena combine the one with the other.

The simplest combination occurs when two attacks of a different nature, each caused by different and independent psychological phenomena are in juxtaposition, succeed each other, and seem to constitute one and the same crisis. Is., a few years past, had a sad adventure. She was violated and was confined clandestinely. Since that time, as may be surmised, her mental equilibrium has been upset by this recollection. She has nocturnal and even diurnal dreams, in which she sees hell, hears her mother reproach her from heaven, and resolves to die, etc. It is the ecstasy attack. But lately she was frightened in seeing someone fall down in an epileptic fit, and the terror provoked in her suffocations, tremblings, convulsive spasms—the emotional crisis. These two crises became combined. To-day Is. feels terrified and trembles, thinking, quite against her will, of the scene she witnessed, and falls into convulsions. After a few minutes she remains immovable, her eyes closed, and she appears asleep. If you examine her well, you will see that tears are flowing down her cheeks and that her lips move, and you hear a few words such as " Mamma, mamma . . . ." It is the dream of remorse, as may be established in putting her to sleep, or simply by studying the subconscious fixed ideas which persist after this attack. Behold, then, in this case two independent attacks—one emotional, the other ecstatic—which are in juxtaposition.

Another example: Dum. was frightened one evening on seeing a man, lying in a ditch, suddenly rise up before her. A very simple terror attack, which repeats itself

regularly. Later on she is struck on seeing a patient attacked by a strange chorea and begins imitating her. Her attack now is doubled: 1st period, emotional; 2d period, rhythmic chorea, in which she stands up erect, stamps on the floor with her right foot, and strikes out with her fist.

We can understand how these combinations may take effect in various ways. The same fixed idea may in its development engender attacks of different forms, according to the psychological phenomena it gives rise to.

Pa. is a young girl who dreams of a butcher-boy called Alexander. Nothing more natural; but as she has no great power of attention, nor a field of consciousness large enough to dream about him without keeping her eyes half closed, she stays in a state of absolute immobility and insensibility. It is the ecstasy attack, which lasts half an hour. The end of the dream is bad. Alexander shut the door in the face of the smitten girl, and this cruel remembrance keeps coming back to the mind of the ecstatic maiden, who groans and laments and ends her dream with a few convulsions. Gib., whose very interesting story will be studied more completely in respect to somnambulism, fell ill on learning of the death of her niece, who threw herself out of the window in a fit of delirium. First, she had ecstasies thinking of Pauline; then more restless dreams, accompanied by motions in which she tried to throw herself out of the window, too; somnambulisms; finally, attacks of convulsions, evidently induced by the emotion this painful recollection awakened in her enfeebled mind. In fine, these different forms of attack combined so as to form the present crisis. In a word, several fixed ideas or a single one can, by development, give place to attacks far more complex than those we have studied above.

If this is so, it may happen that with very low hysterics, who have gone through all sorts of emotions, all sorts of attacks may unite in a single one. This crisis

will then take the name of complete attack, because it will contain about all it is possible to observe during an hysterical attack. Cases of this kind are, if we are not mistaken, what MM. Charcot and Paul Richer have described under the name of grand attack of hysteria.[1] These remarkable descriptions, made formerly without any psychological preoccupation, are extremely important, even from this new point of view. The first phase of the grand attack, the epileptoid period, appears to us to correspond, at least in part, to the emotional attack. The forcing of the phenomena of an epileptic nature into the manifestation of violent emotions is not surprising. Phenomena of this kind have been often pointed out; they belong to that vast category of organic disturbances which accompany emotion, and which are far from being as yet clearly understood. The second phase, the period of clownism, with its large movements, regularly rhythmic, recalls the tics, the strange contortions, so frequent with hystericals, who repeat indefinitely any absurd movement as soon as they start on it. The third and fourth phases, the periods of passional attitudes and delirium, are not, as M. Paul Richer often remarks, only varieties of ecstasy, dreams played or spoken. We do not reproduce here the examples described by M. Paul Richer, for they are known to all; it is enough to recall them to show that the question is of a mixture, a juxtaposition of phenomena which we have studied in an isolated state.

This description of the grand attack of hysteria has been the object of many controversies. It has been justly remarked that attacks of hysteria become modified by imitation or training, and some pretend that such attacks do not develop naturally, but are due to artificial construction. It is not to be denied, we think, that in

[1] Charcot, *Mal. du syst. nerv.*, i., p. 367, et appendice par M. Paul Richer, i., p. 435.

many hospitals and even at the Salpêtrière, certain attacks have become modified by imitation according to this pattern; but are there any attacks that occurred naturally corresponding to this description? Many authors have already written out cases absolutely similar.[1] We would recall on this point two of our old observations. They have no other interest than by reason of the circumstances under which they were made. The question bears on two patients living in the same provincial town, Havre, one of whom has never been in Paris and has never set foot in any hospital whatsoever. Their attacks developed at home, in their own dwelling, without there having been a single example before their eyes. We gathered the observations at a time when we had not yet the honour of being a pupil of the Salpêtrière, and when we had certainly not an exact notion of discussions relating to hysterical attacks.

The grand nervous crisis of Rose developed in the following manner: After some uncomfortableness, more or less prolonged, she suddenly fainted. The muscles were flaccid, the face pale, no gesture, not any motion that manifested consciousness. Very often this initial syncope, which lasts with her a considerable time, brings on respiratory troubles, deep and dangerous: the breathing is now rapid, now panting; now it stops for a whole minute. There is at first some tremulousness in every muscle, without any ensemble in the movements; then movements in the limbs, but altogether inco-ordinate. . . . It seems to us that the movements, at first quite isolated and incoherent, become more and more general and systematic. For instance, at the beginning the muscles of the arms contract at haphazard, one opposing the other, which produces simply a tremulousness of the arms and various flexions of the fingers. They agree well enough for the two arms to make large movements which give blows with the fist on the same part of the chest. Now we know that she has on this place, under the left breast,

[1] Charcot, *Leçons du mardi*, 1888–89, p. 424.

a continuous pain, produced, we think, by a permanent and painful contracture of the intercostal muscles; we believe, therefore, that these movements of the arms are now co-ordinated by this painful sensation. But gradually, after this period of convulsions and contractures, and mixing with it, for there is no abrupt transition, there begin quite other movements. She sits on her bed (she does not get up, for she has both legs contractured during this crisis), bows, salutes with her hands, and smiles to the spectators around. She has been a public singer in a café-concert, and she fancies herself probably on the boards, for she gives us very funny little songs. Or, again, she no doubt fancies herself listening to her companions, for she keeps her hand before her mouth to command silence, appears to listen with delight, and now and then applauds the singer.[1]

After this she wakes, either immediately or after a more complete somnambulism.

The attack of another patient, Lucy, was a grand attack, at least in its duration, for it lasted about five hours. Its evolution was about regular. After a rather long aura, characterised by unconscious terrors such as have been described above, the patient fell suddenly over, immovable, wholly contractured, breathing apparently with difficulty, her face becoming purple; all this followed up by large, rapid movements: arc of a circle, salutations, kicks, etc., and all at once she would stand erect, with open eyes. She would look fixedly at the curtains of her window, and keep her arms raised in a position of terror. We learned later, questioning her during a deep somnambulic sleep, that she was having then a most terrifying hallucination and thought she saw men hiding behind the curtains. For nearly an hour she did not change her attitude, making simply a few movements of desperate defence or uttering inarticulate cries. Lastly, she became more and more restless and entered into a kind of very curious somnambulic delirium, dur-

[1] *Autom. psych.*, 1889, p. 49.

ing which she had the singular habit of going down into the kitchen and preparing for herself an elaborate dinner, which she ate with good appetite, while when awake she refused to eat.[1] These two observations resemble strangely those described by MM. Charcot and Paul Richer. In the first, the epileptoid period is more distinct; in the second, the phase of the passional attitudes is extremely characteristic ; but the two attacks no less conform to the classic description. As for us, taking note of the conditions in which these two observations have been gathered, we are inclined to believe that this kind of complete attacks develops sometimes in a quite natural way.

We shall add only that this phenomenon is somewhat rare. On a quite large number of patients whom we have ourselves studied for the first time we find only these two examples that entirely conform to the known description. Hysterias may be extremely grave without presenting these crises. We do not think that the gravity of a hysterical state need be measured by the presence or absence of this particular symptom.

This attack, despite its uncommonness, is very important. First, it represents, from the teacher's standpoint, a type, a truly admirable schema. A single attack shows all that the hystericals are capable of doing, and other crises can be presented as detached fragments of this attack. The description of M. Charcot's complete attack allows the putting in order of the very difficult exposé of the various hysterical attacks. This attack is also interesting from another point of view. The order of the phenomena which succeed each other is rather regular with this class of patients, and does not seem to be arbitrary. With most the phenomena of delirium, and especially of somnambulism, only develop at the end of

[1] *Autom. psych.*, p. 50; "L'anesthésie hystérique," *Archives de neurologie*, 1892, i., p. 333.

the attack. Epileptoid convulsions, when they present themselves, are far more frequent at the beginning. Now, these two manifestations correspond to two very different psychological states. At the beginning of Rose's attack, when she faints, grows pale, and her members present only vague tremours without any ensemble movements, we cannot provoke or establish any very clear psychological phenomena. The suggestions are not executed; the peripheral impressions, if felt, are nowise understood, and we cannot even succeed in provoking that state of elementary catelepsy in which the members keep the positions in which they are placed. A little later, in the period of the convulsive movements, the movements are associated, co-ordinated, by a painful sensation. One may, moreover, easily provoke cataleptic postures and even simple movements in relation to determined sensations. Lastly, in the following phases there are evidently already complicated dreams. One may enter into relation with the subject, provoke some echolalia, give suggestions which may be executed, direct the course of the dreams, etc. The attack at this moment may easily be transformed into a complete somnambulism, namely, into a veritable psychological existence. Is there not here an evident development of psychological phenomena? Does not the subject seem to have passed from a state where consciousness is, if not null, at least scattered and rudimentary, to a state where consciousness is much more developed and presents again a certain unity? Without taking up again here these considerations which we developed formerly,[1] we think, moreover, that this kind of attacks allows us to be present at the formation of a second psychological existence. The study of M. Charcot's complete attack takes us, as a necessary introduction, to the study of somnambulism.

[1] *Autom. psych.*, p. 49.

§ 5—AUTOMATISM IN THE ATTACK AND IN FIXED IDEAS

Hysterical attacks, when considered from their psychological side, seem to depend on certain emotions, images, or ideas which are reproduced in the mind of the patients. They appear, therefore, to differ but little from other hysterical accidents, and to be connected, as most of them are, with fixed ideas more or less complex. It is, then, possible to resume simultaneously the study of these diverse accidents by examining the general characteristics which fixed ideas assume in hysteria. This study, moreover, can be considerably shortened if we remember the characteristics and conditions previously studied in regard to suggestion. It is not difficult, in fact, to establish the very great analogy which exists between suggestions and fixed ideas.

It is not necessary to dwell on the *duration* of such fixed ideas. This characteristic was manifest in all our observations: hyperæsthesias, paralyses, contractures of psychical origin may last for years. Maria, at the age of thirteen, stopped her menses with a cold bath and at nineteen had, in consequence, a grand attack. Lucy, at the age of nine, saw men hiding in the curtains, who frightened her, and at twenty-one she has still every day a terror-attack during which she remains an hour in apparent contemplation before her curtains. The *frequency* of the repetitions is also evident. Tics, spasms, attacks repeat every day, and even several times a day, the same old incident. Neither shall we study in detail the *ease* with which these fixed ideas develop, when they are once well organised in the mind. The least thing, the most insignificant sign, suffices to release the spring and provoke the apparition of a long succession of images. These images are so precise and so complete that they become constantly transformed into *hallucinations* and *movements*. These are characteristics which have already been

described in regard to suggestions, and which are presented here without modification.

We think it more important to dwell on an essential characteristic of these fixed ideas, namely, their *regularity*. A few patients, the simplest, have but one fixed idea, ever the same, and it reappears always, under all circumstances. M. has had contractures of the masticating muscles, spasms of the œsophagus, contractures of the diaphragm, of the abdominal muscles, of the sphincters, of the anus and urethra. This is her hysterical symptom, and it is the only one she continually reproduces. At a reproach, a grievance, a fright, etc., she contractures all the muscles which relate to the digestive system, and she has never any other accident. Justine will have her fixed idea about cholera and the attack which manifests it, no matter what event happens. Vel. has had for eight years his regular nose-tic, as has been seen, by the subconscious remembrance of a crust in his nose. He was cured very soon, and left us. Seven months later he wrote us that in consequence of family misfortunes and losses of money in his business he was again ill. What accident may, now, this hysterical man, predisposed to fixed ideas, present, in consequence of money losses? Sadness, ideas of remorse, of ruin, etc.? No; he comes back with his tic of the nose and with his subconscious idea of a crust lodged in it. He is cured once more. Some months after, he is attacked with diarrhœa, with a slight cholerine, and again the tic of the nose reappears. Medically, he is the man with the crust in his nose. It is indispensable that this be known, in order to treat in him any kind of accident. One might, in seeing cases of this kind, deny the relation which we have established between the hysterical accident and the provocative cause; but we must prove that in these cases the hysterical accident is not primitive; that it is but the repetition of an old accident which had formerly its *raison d'être*, and

which is being reproduced every time when the moral resistance of the individual is on the wane.

When we consider the very development of this fixed idea, we establish the same regularity. Choreas, contractures, like attacks, remain always the same with the same patient. The processes which have once succeeded in provoking or arresting an accident always succeed. The sensation which these processes determine is associated with such or such element of the fixed idea and brings them regularly along in its wake. It is enough to raise Lucy's arms up in an attitude of terror, it is enough to gape before Ro., to provoke their attack, and the succession of the facts will always be perfectly regular.[1] Is it not curious, on entering the Salpêtrière, to find former patients, Wittm., Hab., Cles., exactly the same as they were described fifteen years ago? If you wish to act upon their symptoms, stop an attack, provoke or remove a contracture, you must know exactly the old studies they served for. He who does not know them will have no effect upon those patients. No need of saying that he knows nothing about hysteria, but simply that he does not know these particular hystericals.

This regularity has given rise to a number of singular theories and even grave errors. The touch of such or such a part of the body starts spasms, erotic ideas, etc., hence, this point is spasmogenic, erotogenic. The matter will be examined and, what is worse, the disease will be transmitted to other patients. A certain individual cannot accomplish a certain thing except by daylight; hence the day has a dynamogenic influence on him and everything is explained by the number of the luminous vibrations. Thus we have transformed into laws of the malady, and even into physiological laws of the organism, the associations of ideas of the subject.[2] Authors like

[1] Paul Richer, *op. cit.*, p. 728; Pitres, *op. cit.*, i., p. 217, point out numerous facts of the same kind.

[2] *Autom. psych.*, pp. 154, 159.

MM. Noizet, Liebault, Bernheim, have, of course, rendered a great service in showing the enormous influence of suggestion in these pretended physiological laws. To our mind, it is not only the suggestion that intervenes, but also the natural fixed ideas, the habits, the associations of ideas. The experimenter is all the more liable to be mistaken in establishing this regularity, as he is convinced, and justly so, of not having suggested it. It is none the less due to a psychological phenomenon, the nature of which should be determined in every particular case.

When several fixed ideas, as it very often happens, have developed in the mind of the patient, the regularity of the psychological phenomena will evidently be more difficult to perceive, but it does not the less exist. One may establish, we dare not say laws of fixed ideas, but a certain order in which the phenomena generally present themselves. It is rare that several fixed ideas coexist in the mind of the same patient without mutual influence. It is an exception to the rule when certain hystericals have two or more fixed ideas independently developing, each in its own way, as if it were alone. X. has a crisis of convulsions and utters shrieks of pain when she thinks of her husband, and an ecstatic attack full of delicious dreams when she thinks of her lover. Generally it is not so, and fixed ideas are multiform only in appearance. They depend on each other. Is., in consequence of a rape and a clandestine confinement, presents at first an anorexia (fixed idea of subconscious suicide), then anger and violence (subconscious idea of homicide to avenge herself). Finally, she appears cured, but presents a mental strangeness. She cannot tolerate the sight of little children; she wants to beat them; she resists the desire, but if she remains too long with them she has an attack (subconscious dream of her child, the cause of all her misfortune). We should always well distinguish, in the clinical description of a patient, these

secondary fixed ideas from the primitive fixed idea. It is essential to the diagnosis and the treatment.

These fixed ideas conceal each other, and the last appears generally to exist alone. When, in consequence of various circumstances and in particular after a psychological treatment, the last, the actual fixed idea disappears, one will be quite surprised to see another one come up, and this is precisely the preceding fixed idea. This removed, there appears a third, of an earlier date. It would seem that in this case the fixed ideas are arranged in layers, and that they come to light in succcession, one after the other. We formerly dwelt so long on this question of the stratified fixed ideas that we will not say more on this subject here.

Lastly, it should not be forgotten that a mind that has been obsessed by a fixed idea remains for some time, even after the disappearance of the fixed idea, in a state of very particular weakness, very open to suggestions and quite in a condition to receive a number of new fixed ideas. It is with the mind after obsession as with an organ that has suffered a first infection. Even after the apparent cure, it has not quite returned to its state of primitive integrity. The mind, like the organ, remains in a state of receptivity, and if the one is infected by all the microbes which before would have remained without effect, the other is invaded by innumerable fixed ideas from insignificant causes. Justine was tormented for fourteen years by the one fixed idea of cholera. When we removed this primitive fixed idea, we saw the patient traverse a singular period. In the space of a few months she presented a dozen different fixed ideas provoked by the incidents of every-day life. We no sooner removed one, than another sprang up. These are secondary fixed ideas through suggestibility, which it is equally indispensable to know if one would undertake the treatment of these maladies.

In short, properly to appreciate the degree of this regularity in each particular case, there remains a distinction to be made. One must take note of the degree and especially of the long or short standing of the disease. Hysterias that begin, that are still in process of formation, of evolution, are not on this point identical with fully constituted hysterias.[1] At the beginning of the malady it seems that the mechanism of the fixed ideas is not yet perfect nor definitive, and the attacks dependent on them can, up to a certain point, be modified. Suggestions made in varied conditions to reach these phenomena, generally subconscious, new emotions, outward spectacles, which impress the mind either when awake, or even during the attack, may transform and complicate these attacks. We related formerly the story of three hystericals whom we studied first in the different wards of the Havre hospital, and of whom each presented a different attack. Later they were brought together into the same ward, and " I was quite surprised to see that after some time their symptoms were intermingled and that they had all three the same crises, with the same movements, the same delirium, the same invectives against the same individual. Little was wanting for a new type of hysteria to be formed in that ward which later might have been studied as natural."[2] This imitation plays, moreover, a well-known part in the great epidemics of possession. But what is, indeed, interesting is that this disposition of modifying crises through imitation and suggestion is not always lasting. We easily observe, by examining the patients of the Salpêtrière, that the contagion does not play the same rôle with all. The young patients, whose hysteria has just begun, are

[1] For this distinction of the different degrees of hysteria, see *Stigmates mentaux de l'hystérie*, p. 47, above.

[2] *Autom. psych.*, p. 449; Briquet pointed formerly to facts of the same kind, *op. cit.*, p. 389.

very susceptible to this contagion, and every moment you may discover in the attack of one of those patients a certain detail, some feature caught from a neighbour. Bertha starts out crying: "Little woman . . . patapan. . . ." These are her friend Renée's words. Lec. shakes her head as Mar. does, etc. Aged hystericals, on the contrary, whose malady is of long standing, remain unchanged. It seems that Hab. and Cles. do not deign to modify their classic attack by the introduction of features borrowed from small patients newly arrived. Truly, their attacks can scarcely any longer be modified by any process. The organisation of them is definitive, and they have become perfectly regular. There is then a period when the patients organise, so to say, their fixed ideas and their attacks; bring together, systematise emotions, movements, ideas borrowed here and there; transform them more or less through a kind of subconscious meditation. The system becomes more and more regular and ends by becoming unchangeable. The perfect regularity in the association of the ideas, in their succession, is then, indeed, the characteristic, and tends to become more and more clear, as the hysterical malady becomes more confirmed.

Hysteria was formerly considered an eminently variable and protean malady. M. Charcot had repeatedly to insist on the fact that permanency of symptoms was for years frequent with the hysterical. To-day we have come to think that this immobility, if we take note of those innumerable psychological facts which tend to transform everything is, on the contrary, the rule. For years we have the same attacks, the same attitudes, the same stigmata. Far from being too changeable, the hysterical is not sufficiently so. She remains indefinitely the same, under the same emotion, without adapting herself to the indefinitely changeable circumstances around. This last remark takes us to the

study of a second very important characteristic of fixed ideas.

These ideas are not conceived, invented at the moment: they formulate themselves ; they are only *repetitions.* Thus, the most important of the hallucinations which harassed Marcelle during her cloud-attack was but the exact reproduction of a scene which had taken place the previous year. The fixed ideas of dying, of not eating, are the reproduction of certain desperate resolutions taken some years ago. Formerly these ideas had some sense, were more or less well connected with a motive. A desperate love affair had been the cause of her attempts at suicide; she refused to eat in order to let herself die of hunger, etc. To-day these ideas are again reproduced, but without connection and without reason. She has, we convinced ourselves, completely forgotten her old despair, and has not the least wish to die. The idea of suicide comes to her to-day without any relation to her present situation, and she is in despair at the idea of this suicide which imposes itself on her as a relic of her past, so to say. She does not know why she refuses to eat; the ideas of suicide and refusal of food are dissociated. The one exists without the other. At one moment she hears the voice, "Do not eat," and yet she has no thought of death; at another, she thinks of killing herself and yet she accepts nourishment. We always find in fixed ideas this characteristic of automatic repetition of the past without connection, without actual logic.[1]

It is useless to insist upon proving that it is the same in all other cases. We have constantly shown how the hysterical accident reproduces its former event. MM. Breuer and Freud expressed very well the idea we have long maintained when they said: "The provocative cause acts still, after years, just as a moral pain, kept within the remembrance, provokes tears long after the event. . . . The hysterical suffers, above all, from *reminis-*

[1] "Aboulie et idées fixes," *Revue philosophique*, 1891, i., p. 279.

cences." "*Die Hysterische leidet grösstentheils an Reminiscenzen.*" [1]

Not only does the fixed idea require no attention or intellectual effort to develop, but it cannot develop unless *the attention and will are very greatly reduced.* All physical or moral fatigue which diminishes the power of psychological synthesis, favours those accidents due to fixed ideas. When Vel. is sick with a little attack of cholerine, his nose-tics, which had disappeared, return. When Lec. quarrels with her husband, she is taken again by her chorea on the right side. Maria is pursued by the idea of drinking ether at the moment of her menses; and Justine, tired out at the laundry with the family wash, is again a prey to her idea of cholera. Better still, this remark explains to us how certain fixed ideas seem to start up long after the provocative accident. Guinon relates the example of an hysterical paralysis which came unexpectedly two years and a half after a fall.[2] We have just studied the curious example of Col., wounded in a railway accident. He is quite well and reproduces this accident in characteristic crises only six years later, and only when family misfortunes and the sudden death of his wife have put him into a state of depression favourable to the development of the fixed idea, dating far back, which had remained in a latent state in his mind.

This is the opposition between voluntary activity and the mechanical operation of the brain, which for many years past has been pointed out by psychologists, particularly by M. Maine de Biran, with whom M. Moreau (of Tours) fully concurred, as well as MM. Macario, Delasiauve, and other alienists, on whose views we have dwelt at great length in a foregoing work. We think we have somewhat emphasised that opposition which had remained rather vague and have shown its importance

[1] Breuer et Freud, *op. cit.*, p. 4.

[2] Guinon, *Les agents provocateurs de l'hystérie*, p. 319.

in a great number of particular phenomena. It is also in this way that we should understand the rôle of that physical exhaustion which in a few cases seems to reveal fixed ideas, and upon which M. Féré particularly insisted.[1] It interposes indirectly by diminishing voluntary activity and, consequently, by favouring the regular repetition of the old phenomena, of the automatic phenomena. The latter, when they exist, tend still more to diminish the attention and the will. They increase the abulia, continuous amnesia, and absent-mindedness. However, they have not been able to increase except through some previous weakness. This is a vicious pathological circle of great importance, which plays an essential part in the pathology of fixed ideas.

The above characteristics are not peculiar to the fixed ideas of hystericals; they are found more or less distinctly in most phenomena of psychological automatism, in the course of all mental maladies. Do fixed ideas take a more particular character when they develop among hystericals ?

It has been seen that generally the patient was ignorant of the dream that determined the hyperæsthesias or contractures ; he seems to be better acquainted with the dream that determines the attack, since he expresses it by attitudes and words. In fact, the characteristic remained the same. The patient awakes from the attack with a very confused recollection, or even without any recollection of his dreams if one is careful to wait a few minutes before questioning him. This forgetfulness becomes all the more clear and deep as the malady takes shape.[2]

One way or the other, the fixed ideas remain outside the normal consciousness. At one time they develop simultaneously below this consciousness; at another they develop in a nervous state, which takes the place of the

[1] Féré, *Pathologie des émotions*, p. 147. [2] Charcot, *op. cit.*, iii., p. 259.

ordinary consciousness and alternates with it. If sometimes an obsessing idea, an hallucination, say, appears to be well known by the subject, it generally depends on a more complicated dream which he does not know.

As long as the preoccupations, the obsessions, remain entirely conscious, they do not as yet constitute an hysterical accident, so called. A young man of fifteen, Girb., sees a fellow patient attacked by a nervous crisis, and he hastens to his assistance; but the patient in his contortions clutches at him and bites him in the leg. Girb., very much excited, leaves the man in his convulsions and gives up caring for him. Here we have now a young man much preoccupied, and the following days, instead of attending to his day's work, he goes to look up that sick man, "to find out," he says, "why he bit me; whether he did it on purpose, returning to me thus evil for good." He cannot find him again, but persists in looking him up; he cannot eat, cannot sleep, ever obsessed in a quite conscious manner by this idea of a bite. Three months later, after some quarrel, he falls into convulsions, and then during an attack he jumps about on all sides seeking to bite the bystanders. Coming to himself, he does not remember the extravagances he committed, nor the attentions he has received. From that time on he has similar attacks every other day, but he is no longer in any way obsessed by the thought of the man who had bitten him—never thinks of him again. The fixed idea, at first conscious, has formed an hysterical attack and remains now in a greater or less degree subconscious. It is true that in certain rare cases the fixed idea, which has been for some time subconscious, may regain consciousness and induce deliriums, which we shall study later. But these are rare accidents, which hardly belong to hysteria proper.

Finally, this subconscious character of the fixed ideas with hystericals plays a great part in the therapeutics of

these affections. We formerly showed that it was necessary to look up, so to say, these subconscious phenomena in order to attack them, and that one could not treat the hysterical accident before having reached those deep layers of thought within which the fixed idea was concealed. We are happy to see to-day MM. Breuer and Freud express the same idea. "It is necessary," they say, "to make this provocative event self-conscious; bring it forth to the full light. The accidents disappear when the subject realises those fixed ideas."[1] We do not believe that the cure is so easy as that, and that it suffices to bring the fixed idea to an expression to carry it off. The treatment is unfortunately of a much more delicate nature, but, in any case, it is certain that this discovery of the subconscious phenomena is an indispensable preliminary.

In a word, the fixed ideas of the hystericals present to the highest degree the characteristics of psychological automatism: regularity, repetition of the past, and subconsciousness. They are the same characteristics which have already been established in suggestions. Fixed ideas are phenomena of the same kind, which develop in the same manner in minds of weakened synthesis. Both indicate a division of the phenomena of consciousness which we shall see completely manifested in somnambulisms.

[1] Breuer et Freud, *op. cit.*, p. 4.

CHAPTER IV

SOMNAMBULISMS

THE psychology of somnambulism has been the subject of many studies. We have ourselves, in a foregoing work, set forth a few considerations which seem to us still quite sound. Besides, M. Georges Guinon is to publish shortly in the Charcot-Debove collection an elaborate work on somnambulisms. It is, therefore, both impossible and useless to go over this study in a complete way again. Yet somnambulism plays a considerable rôle in the pathology of hysteria. It is the terminus and conclusion of a great number of subconscious fixed ideas and attacks, and we cannot pass it over entirely. We shall limit ourselves to a brief description of the principal varieties of somnambulism, and, without dwelling on the psychological theory of these states, we shall only point out their medical importance in showing their relations to the other accidents of hysteria.

§ I—GENERAL CHARACTERISTICS OF SOMNAMBULISMS

It is a fact of popular observation that hystericals may at certain moments pass into abnormal psychological states, the first characteristic of which is to appear strange, extraordinary, very different from the normal psychological state of the subject. Physicians have naturally endeavoured to give precision to that which constituted the abnormal character of these states; to explain

the exact phenomena serving to characterise and diagnose the somnambulic state. It does not seem to us that this research has met the requirement, nor that there has been discovered, in the attitude of the subject, in the state of the organic functions, in the modifications of the sensibility, of the movement or will, a characteristic, always the same, that separated the somnambulic state from the waking state. All the characteristics that have been proposed are far from being constant in somnambulism, and are very frequently found to exist in the waking state.[1] We are obliged to come back to the popular remark and to be satisfied with giving it precision. Somnambulism has no characteristics of its own; it is simply an *abnormal state, distinct from the normal life of the subject.* Given a person who can be examined only at a certain moment of her life, it is impossible to determine in what state she happens to be. Lucy, M., Bertha, and many others may be examined during their somnambulism without anyone's being able to say what state they are in. In order to recognise it, it is necessary to be able to compare their state with their normal life and prove that there is in these two periods another repartition, another equilibrium of the psychological phenomena. Somnambulism is a second existence which has no other general characteristic.

This difference between the two states may be very broad and easily noted. Certain anæsthetic subjects, paralytic, contractured when awake, have no trace whatever left of their malady in somnambulism, but these cases are rare and the psychological difference is generally slight. It would be very difficult to appreciate and would mostly be passed by unperceived, if it did not bring with it a very apparent psychological phenomenon. Memory is a delicate faculty which is disturbed by even slight

[1] Discussion of the characteristics proposed for the diagnosis of somnambulism, *Autom. psych.*, p. 67.

modifications of consciousness hardly perceptible. This difference of the two psychological states is enough to provoke a scission in the continuity of the recollections—at least of the reasonable and personal recollections. On awakening from the second state, the patient cannot recall the events that have taken place during that period; he cannot recover those recollections unless he re-enters the state that has given them birth. The modifications of the psychological states, though real, do not deserve the name of somnambulisms, so long as they are not strong enough to bring about naturally this disturbance of the memory; and we reserve the name *somnambulism for states in which the subject possesses particular recollections which he finds no longer when he returns to his normal state.*

This first characteristic evidently raises difficulties; it will not be clear in many of the intermediary cases where the recollections are but incompletely and slightly effaced on awakening. Should we consider as somnambulisms those states into which Justine enters in the wake of her fixed ideas? She seems to have lost the remembrance of them the moment she wakes, and yet she recovers these recollections spontaneously after a few days. Should we also call somnambulism Ba.'s state, which he forgot on awakening, but of which he regularly recovers the recollection the next morning after dreaming about it in the night? These cases and others may be embarrassing, but we are obliged to formulate the definitions according to the typical cases and not according to intermediary varieties.[1] Forgetfulness, on awakening, remains the essential characteristic of somnambulism, properly so called.

We shall add only a single characteristic to give more precision to this definition and distinguish somnambulism

[1] We cannot reproduce here our studies on the verification of forgetfulness on awakening, and its irregularities, *Autom. psych.*, pp. 74 and 174.

from the attacks, the ecstasies, of which the subject does not retain any remembrance. In these attacks the subject confines himself to dreaming and to expressing his dream. He takes no cognisance of the outer world and does not adapt himself to it. In somnambulism, we establish a more considerable intellectual development, which permits the patient to see and hear in a conscious manner, and to perceive the impressions which struck his senses and to adapt his conduct to the surrounding phenomena.

An example will explain. A young girl, seventeen years old, Rah., presenting already, especially at the time of menstruation, a few hysterical symptoms, was in the service of an individual who, according to the present fashion, pretended to know about hypnotism. This man attempted to hypnotise his servant, with a view of taking advantage of her sleep to violate her. He succeeded in provoking convulsive attacks, in which the young girl could defend herself. These attacks looked somewhat like the somnambulic state, for, in coming to, or awakening, Rah. knew nothing of the attempts she had been the subject of. However, a few days later, this young girl was obliged to return to her parents because of a strange malady. She was at first absent-minded, anæsthetic, forgot what had recently happened, was unable to do any work, and could not understand what was said to her. This is the resultant state of abulia as is known from the development of a subconscious fixed idea. Besides, in the night, she moved about in her bed, cried, called for help, fought convulsively, and, sitting up, kept her eyes fixed and arms stretched out before her as if in the act of repelling someone. Then she would jump down from the bed, run across the room, and escape out of it. The scene would then change; she seemed to grow calmer and looked at the surrounding objects; she would take a common thing, as a broom, and begin to sweep

the floor quietly. One night she left the house, and, seeing a wheelbarrow in the yard, began filling it with sand and wheeled it to the bottom of the grounds. Sometimes she would wake in the midst of her work in the greatest consternation, not knowing what she was about. Generally she would then return to her room, go to bed, and fall asleep again. It seems to me easy to distinguish two periods in this accident: one in which the patient thinks of her hypnotiser and does not see the surrounding objects; the other, in which she experiences sensations and allows herself even to be guided by the objects that present themselves to her. These two periods evidently depend upon each other, but we can, at least for the sake of clearness, distinguish them and consider the first as an attack determined by a dream, and class the second as somnambulism. We then admit that the somnambulic state depends on two characteristics: a certain disturbance of the memory after the abnormal state, and yet a certain degree of intelligence during the abnormal state which, up to a certain point, permits the perception of outward phenomena. Each of these two characteristics is susceptible of numerous variations, and it is for this reason that we admit two classifications in somnambulisms—one determined by the study of the modifications of memory, the other by the consideration of the degree of intellectual development.

§ 2—THE VARIETIES OF SOMNAMBULISM CHARACTERISED BY THE MODIFICATIONS OF THE MEMORY

Somnambulisms are very numerous and very varied, and they should be classified. Can we take for the principle of this classification the duration of these abnormal states? We do not think so, for all or nearly all the forms of somnambulism are susceptible of being indefinitely prolonged. Their duration may vary from some minutes to several months. A more interesting

classification distinguished these abnormal states, according to their origin, as natural somnambulisms and artificial somnambulisms. This distinction may in certain cases be of great practical use; it does not, however, seem to us very exact. We must not believe that induced somnambulisms in a subject are, in nature, different from the natural somnambulisms of the same person; they are generally absolutely identical.

It has been remarked that, in certain cases, the subject presented during an induced somnambulism a greater docility, seemed deprived of spontaneity. This is far from being the case generally. Certain somnambulists, like Lucy, Bertha, and many others, are less suggestible during their state of induced somnambulism than when awake. The independence and spontaneity of the patients during natural somnambulisms are more apparent than real. If we know the patients well, if we succeed in capturing their attention, in entering in some sort into their dreams, we can more easily control them. Some authors have remarked, quite justly, that natural somnambulism is generally filled with a complicated dream, with hallucinations, and they have thought that this characteristic was not found in induced somnambulism. We cannot share this opinion. Subjects who have fixed ideas express them perfectly during induced somnambulism; it is enough to leave them to themselves a little while in that state without attempting to direct them. Justine, Mme. D., among the patients we have described, have very minute dreams, fixed ideas, impulsions while in induced somnambulism; and it is very often difficult to regain the direction of their thought when for a moment it has been suspended. In fine, the analogy of these states is such that the subject seems to pass over from one to the other with the greatest ease. In fact, he remains in the same psychological state, but we take more or less the guidance of his thoughts.

The truly useful classification, it seems to us, should be based on the two most important psychological characteristics: the state of the memory and the development of the intelligence. Let us first examine somnambulisms from the first standpoint.

We know that memory, in all somnambulisms, is lost on the subject's awakening. If we consider not the remembrances which the subject may have when awaking, but those he is in possession of during the somnambulism itself, we shall establish many variations.

1. *Reciprocal somnambulisms.*—The somnambulisms of reciprocal memory, or, to be more brief, reciprocal somnambulisms, are states in which the remembrance of the first is found in the second and the remembrance of the second in the first. For instance, Marguerite had a kind of delirium consequent upon her hysterical attacks. To speak more precisely, she had at the end of the attack two periods of different somnambulism. In the first, she remained immovable, her eyes closed as if she were asleep. She does not answer you and appears not to hear, although in reality she hears very well. In the second, she opens her eyes, moves about, and speaks naturally; but she does not recognise the persons that approach her, and seems to have forgotten all the events which happened since she was ill. This last period terminates with some convulsions, and the patient wakes in her normal state. Although the two somnambulisms, the one as well as the other, are forgotten upon waking, they are not identical and are not reciprocal. Question the patient when she is in one of those states, whether her eyes be shut or open: it will be found that she has no notion of the other state. On the contrary, if we observe the same patient in a new attack, if it be some months after the first, we shall see her reproduce her two somnambulisms. During the first, we shall obtain a few words by insisting, and we shall be able to establish that

Marguerite remembers persons who approached her bed and the words they spoke while she was in the same state. When the second somnambulism follows, as it naturally will, we shall see that Marguerite, although she has forgotten all the rest, remembers exactly what passed in the period corresponding with her attack. At this moment, too, she knows only certain persons—those, namely, who spoke to her during this period of attacks. The new somnambulisms are reciprocals of the first.

It is so, generally, when somnambulisms are regularly reproduced under the same conditions. Many patients continue exactly in a new somnambulism an act begun in the first, like that patient described by M. Mesnet, who went again in somnambulism to look for poison concealed in a closet during a first attack, or like that young man described by M. Guinon, who wrote a long story while in a somnambulic state and regularly resumed the tale at the point where he had been interrupted.[1] Mary Reynolds, the patient of M. Weir Mitchell, had entered after a sleep into an abnormal state. She had no longer any knowledge of the past whatsoever and was obliged again to learn to read and even to speak. This condition ended after a few weeks, and the patient returned to her normal life without any memory of what had lately happened. When the second state reappeared, Mary Reynolds had retained the knowledge acquired in the first abnormal period and just continued her education. It is the same concerning artificial somnambulisms when they are induced by the same person and in the same way. But sometimes, when the somnambulic state is not produced in the same way, it differs slightly,—enough, however, for some disturbance of memory, and for that reciprocity to disappear. Marguerite, put to sleep by M. Dutil, could not recover the recollections of the somnam-

[1] Georges Guinon, *Progrès médical*, 1891, No. 20 *et seq.* Cf. *Autom. psych.*, p. 78.

bulism which we had ourselves induced, and when put to sleep again by us, could not recover the remembrances of the somnambulism induced by M. Dutil. A patient of M. Pitres's ward, Jane R., had been violated in a somnambulic state; put to sleep again she could, however, not recover the remembrance of this incident and then said: " I cannot remember what has happened; it seems to me I was put to sleep differently." (Oral communication of M. Laurent.) In cases of this kind, one succeeds almost always in recovering the reciprocal remembrance by modifying the somnambulic state in various ways; by, so to speak, a sort of fumbling, feeling about.

This reciprocity is particularly interesting and practically useful when it exists between a natural state and an artificial state. Thanks to this fact, we have been able to recover during artificial somnambulisms the minute recollections of the attacks, deliriums, natural somnambulisms. If we continue to study the patient Marguerite, we shall see that with her we can induce artificially a state in which she also remains stretched out, eyes closed, and, if you insist on it, speaks with difficulty. She tells us what happened during the first period of sleep which follows the crisis, that such or such a person came to her, that her father kissed her, etc. Reciprocally, if we now tell her something, she will be able to tell it to us in her next crisis, during the same period of sleep. We have, then, here two states of reciprocal memory.

While she is asleep, let us oblige her to open her eyes; there will happen then, during the somnambulism, a thing far from the ordinary: her condition is wholly changed and she loses the remembrance of what she has just now told us when her eyes were closed. But, on the other hand, she has acquired entirely new recollections. She tells us what happened during the second

somnambulisms of her attack, and, reciprocally, during the period of the attack; she remembers her artificial somnambulisms with her eyes open. Here are again two reciprocal states.

Facts of this kind have been very often established. We shall recall only that it is possible, during induced somnambulism, to obtain an exact account of those long flights (*fugues*), of those strange excursions, accomplished automatically, of which the patient has not the least recollection.[1] This is a very important characteristic and connects a great number of somnambulic states.

2. *Reciprocal and dominating somnambulisms.*— For want of a clearer expression, we say that a psychological state—B, for instance—dominates another psychological state, A, when it presents itself in the following relation with it. The subject, placed in the state B, remembers the state A, but the contrary is not true; for, when he finds himself in state A, he does not remember state B. This fact is interesting, for it is characteristic of the most ordinary somnambulisms.

In fact, it is quite rare to establish somnambulic states like those of Mary Reynolds, or Marguerite's second somnambulism with eyes open, in which the subject remembers only periods exactly corresponding, and has no other remembrance, either of normal life or of any other state. Generally, the subject placed in a somnambulic state retains not only his language and general habits, but also the exact recollections of the time when awake. Some somnambulists do not pretend to this; they look upon such recollections when awake and speak of them as if the question were of another than themselves; yet they can nevertheless recover and express all these remembrances. Generally, the somnambulic state dominates the waking state. It may be said, from the

[1] Pitres, *op. cit.*, ii., p. 277; Saint Aubin, *Fugues hystériques*, p. 15; Tissié, *Les rêves*, p. 84; Laurent, *Les états seconds*, p. 24, etc.

standpoint of memory, that it is superior and the waking state inferior.

3. *Somnambulisms in gradation.*—In certain cases, the foregoing characteristic is still more complicated. There is being formed a series of varied states, having between them these relations of superiority and inferiority.

The following observation, borrowed from a celebrated magnetiser, is better than a description: A young girl, from thirteen to fourteen years old, fell into various nervous states distinct from the waking state; nervous crises, natural somnambulism, artificial and magnetic somnambulism.

Although the patient had the free exercise of her intelligence in all these different states, she did not remember, when in her ordinary state, anything she had done or said in any of these states; but what will appear surprising is, that when in the magnetic somnambulism, *dominating*, so to say, all the species of lives she enjoyed, she remembered all that had happened during either somnambulism, or her nervous crises, or when awake. In noctambulism, she lost the remembrance of the magnetic sleep, and her memory extended over the two *inferior* states only. In the nervous crises she lost the recollection of noctambulism; finally, when awake, as at the lowest degree, she lost the remembrance of all that had happened in the *superior states.*[1]

We have already ourselves recorded several observations of the same fact.[2] The different states which we had designated by the numbers 1, 2, 3, formed a gradation such, for example, that state 2 dominated state 1 and was in its turn dominated by state 3. Without returning to that description, we shall add only that, with some patients, these states are clearly separated from each other either by periods of sleep, or by convulsive

[1] Bertrand, *Traité du somnambulisme*, 1823, p. 318.

[2] *Revue philosophique*, 1887, i., p. 449; *Autom. psych.*, p. 85.

accidents, as is the case with Lucy, Rose, etc., but with others, as with M., the transition is inappreciable. Be it during a state of induced somnambulism, or even during an apparently normal state, M. remembers at one time more and at another less. It would seem that the power of the mind rises or falls incessantly, according to the emotions, the fatigues—according to a thousand conditions, and that the memory manifests in her these fluctuations. This patient will be better understood when we shall have studied other characteristics of somnambulism. Let us be satisfied with knowing that the range of the memory is variable in somnambulisms and that this characteristic enables us to distinguish among these abnormal states a few varieties.

§ 3—VARIETIES FROM THE STANDPOINT OF INTELLECTUAL DEVELOPMENT

Somnambulisms present a second important characteristic—namely, that the patient is not wholly isolated in his dream; he perceives outward things and conducts himself according to his perceptions. It is true that this intelligence is very variable and, according to the degree of its development, there result very different psychological states.

1. *The hemisomnambulisms.*[1] — This state has been especially the object of experimental studies which we have presented elsewhere, and which it does not seem worth while to reproduce here. We think, however, that it may be well to recall its existence—first because this condition may sometimes be naturally produced, and then because it forms an interesting transition between subconscious fixed ideas and somnambulism, properly so called.

[1] Ch. Richet, *Les mouvements inconscients dans l'hommage à Chevreul*, 1886, p. 93.

In all the symptoms of the mental state of the hysterics, we have always established a double characteristic: (1) The personal perception was diminished, and allowed certain psychological phenomena — sensations, remembrances, motor images—to escape the consciousness; (2) the neglected phenomena, not perceived by the personality, were not, however, entirely suppressed; they existed in a state of isolation, apart from consciousness. These subconscious phenomena may in certain cases group themselves, co-ordinate themselves, so as to form thoughts sufficiently complete and isolated.

The fact is especially quite clear and well known in a particular case—the automatic writing of the medium in spiritualistic séances. This person seems to be wide awake and can take part in a general conversation or even read aloud, and yet, at that very moment his hand, carried away by a motion he cannot account for, writes, without the help of his will or his thought, things which he is himself ignorant of, and which he is much surprised to read afterward.[1] Others act: imitate—without being able to account for it—the face, the voice, the gait of the persons engaged, and play scenes in their life; others, in fine,—the most curious, perhaps, from a medical point of view,—cannot prevent their lips from speaking words of whose sense they have no idea, and which they are quite surprised to hear. "The same power works in them on the organ of speech as works on the hand of the writing mediums . . . the medium talks without being conscious of what he says, although he is perfectly awake and in his normal state."[2] The visual or auditive mediums hear words despite themselves, or behold scenes which they afterward relate voluntarily.[3]

All these facts have their analogies in the accidents

[1] *Autom. psychol.*, p. 380.
[2] Allan Kardec, *Le livre des médiums*, 19e édition, p. 203.
[3] Allan Kardec, *op. cit.*, p. 203.

which happen naturally to hystericals. We often meet similar ones in the description of the possessed. M. Carré de Mongeron, who describes the *convulsionnaires* of Saint Medard, relates the following fact: "It often happens that the orators deliver a succession of words independently of their will, so that they listen to themselves, as it were, like the bystanders, and they are acquainted only with what they say as they pronounce it." The same fact was formerly noticed among the little prophets of the Cévennes in the revolt of the Camisards.

To-day we frequently establish facts of this kind. Renée begins to vociferate insulting speeches, and from time to time takes advantage of an interruption to say, whining: "It is not my fault; it is not I that say all this; I never knew such bad words." An hysterical patient whose observation, noted by M. Huet, was published by MM. Séglas and Bezançon, was tormented by this automatic writing:

The beginning of this actual affection goes back two years and a half. At that time, after having read M. Allan Kardec, and on the assurance of a neighbour, she began to make tables move. . . . This winter (October, 1887) she has done writings; she was told to try, and taking a pen and paper she wrote right off. Before writing she would put a question; she then feels her hand taken hold of, and experiences within it something like a cold fluid, and she writes, in spite of herself, she says, the round script, the half-round, neither of which she knows, and signs her father's name, etc. . . . The writing would change every time; when she writes herself, she does not feel her hand taken and appreciates the difference. Sometimes when she writes to her parents, the spirit seizes her and she writes what she would not write. She thought at first that the spirit that possessed her was her brother; but she found that she was mistaken, because that spirit makes her write the round and half-round hand, which was not her brother's way. It is a demon, an evil spirit, that of a learned

man, a former professor of the seminary, a man who knows seven languages, but lost.[1]

Among our patients, Lucy, Marguerite, and many others present in a complete way the automatic writing, and would make the fortune of a spiritualist circle. Gib., whose curious observation was communicated to us by M. Dutil, had been much upset on learning the death of her niece Pauline, who, in an attack of delirium, threw herself out of the window. Since this event, she is sad, preoccupied, unable to do any work, nor give attention to anything, and she pretends not to know what troubles her or to understand the ideas that obsess her. Yet, when she has a pencil in her hand, she scribbles at random on bits of paper, and in these formless marks one can recognise the design of a window and the name of Pauline. If you take these papers away from her in time, before she has looked at them, she cannot guess what is on them.

That which characterises all these facts, and especially this writing, is, (1) that the question is one of involuntary movements, unconscious and yet intelligent, and (2) that these movements take place while the normal thought and consciousness of the subject remain quite intact. The first characteristics, the absence of will and consciousness, will always be doubted so long as one shall not have directly observed, and at great length, the subjects of this kind. One must see these persons reveal, without their knowing it, what they wish to keep concealed, and what they think they have not told anyone; one must know the situations and characteristics, to be convinced of this fact. The intelligence that thus manifests itself is far from being remarkable; but clear

[1] J. Séglas et Paul Bezançon, "De l'antagonisme des idées délirantes chez les aliénés," extrait des *Annales médico-psychologiques*, janv. 1889, p. 20.

perceptions of the exterior world and simple judgments may nevertheless be established. These automatic writings may be replies, considerably long ones, to questions put in a whisper, while the diverted subject seems to be busy with something else. This diversion is an application of the method of suggestion. Besides, we establish, in these writings, memory, judgment, and even a certain unity in the thought. These messages are often signed by a name, as if some rudiment of personality were forming itself there.

As to the persistency of the normal consciousness, while these automatic phenomena are being accomplished, it is the most curious and most discussed characteristic of hemisomnambulism. It is clear that this consciousness will always be very much restricted, for it is known that the development of the subconscious fixed ideas always reduces considerably normal perception. The subject understands less and remembers less of what is told him during the automatic writing than during the normal state. However, certain subjects, like Marguerite, are capable of reading aloud, of understanding what they read, and of remembering it while their hand replies to quite other questions. This simultaneousness, it will be said, is not absolute; it would be necessary to show by exact measurement the simultaneousness of one movement of the lips and one movement of the hand. This verification, we think, would not prove anything, for we can make voluntarily two simultaneous movements, and this simultaneousness can also be produced by chance. That which is truly simultaneous and impossible to appreciate experimentally is the simultaneousness of the two series of thoughts. They seem, with some subjects, to develop simultaneously; that is all that clinical observation allows us to establish. In other cases, simultaneousness is less rigorous; the hand ceases to write for an instant while the mouth speaks, and takes it

up again the next moment; there is a sort of alternation. But it is curious to notice that the phenomena group themselves, nevertheless, into two very independent series: one which the subject knows very well, the other of which he appears ignorant. There is even a discord established sometimes, a singular contradiction between these two categories of thoughts. Finally, often, even in spiritualistic séances, the automatic writing cannot develop except by more and more reducing normal consciousness and even by causing it to disappear. Hemi-somnambulism transforms itself, then, into somnambulism proper.

2. *Somnambulism in a lethargic form.*—The patients lose consciousness—that is to say, the first series of psychological phenomena which forms their normal personality is arrested. They remain immovable and seem profoundly asleep. If you raise their limbs, you find that they are flaccid and fall back of their own weight. Conditions of this sort, whether natural or artificial, have been often described under the name of hysterical sleep, lethargy, syncope, apparent death, dead or passive somnambulism,[1] death-trance (*mort extase*). We have not to study the physical characteristics of such a state; we simply establish that the psychological phenomena are far from being wholly effaced. The sensations continue to exist, the subject hears; you must be convinced of that, else you express before him imprudent suggestions, which he will execute later. When the subject passes into a more lucid somnambulism, he can often relate all that was said before him during his lethargic state. The sensations of touch still exist and become marks or *points de repère*, signs in the wake of which certain movements, previously suggested, may be executed. Sometimes other psychological phenomena, more complicated, —dreams, for example,—fill the mind of the subject

[1] Despine (d'Aix), *op. cit.*, p. 146.

without becoming manifest outwardly; but generally psychological phenomena cannot become complicated without the subject's entering into a more complex somnambulism.

3. *Cataleptic somnambulism.*—The intellectual state is already a little more developed, but the field of consciousness is as yet extremely restricted; it contains only a small number of ideas simultaneously, or even a single idea only. The latter develops without meeting with any obstacles and induces harmonious attitudes of the whole body, expressive movements absolutely complete, and *en rapport* with the one idea that fills the mind. When you can cause an idea to enter the mind of the subject, you modify his attitude, you cause him to express, successively, prayer, fear, threats, etc.

When this state develops naturally, the subjects remain immovable, in an attitude in accordance with the idea they had in the beginning, or in accordance with their dream. These expressions, natural or suggested, are not many, for the subject does not understand the language of complicated ideas. He experiences simple sensations which, by association of ideas, bring with them certain images and certain movements perfectly determined. For instance, if you say to him, "Raise your arm," he will repeat, like an echo, "Raise your arm," but he does not seem to understand the sense of the words, for he does not really raise his arm.[1] This cataleptic state is often described by the old magnetisers and held up by them as something curious.[2]

4. *Monoideic somnambulism.*—The patient has, according to the case, his eyes closed or open, but he apparently moves spontaneously and has a much more wide-awake look. It is the state of half-waking ecstasy (half-waking trance), somnambulism in action, according to old observers.

[1] *Autom. psych.*, p. 32.

[2] Despine (d'Aix), *op. cit.*, p. 45.

In this state the subject perceives outward things better, and he understands the language addressed to him, but he has a very restricted field of consciousness, and he is incapable of opposing remembrances and other ideas to the one he has once conceived. Therefore he is extremely suggestible, and develops to the end a thought that has once entered into his mind. In artificial somnambulisms this retraction of the mind manifests itself by a curious characteristic : election (elective affinity), the preference which the subject seems to give to the person who has put him to sleep and directs him. He feels the contact of this person only, he hears no other voice than his, hears his words alone, or rather he perceives only certain sensations and remains aloof from all others. This election may be explained in the same manner as hysterical anæsthesia, by a choice which the subject makes automatically of certain impressions, to connect them with his personality to the exclusion of the others.

When this somnambulic state develops naturally, it is entirely occupied with one fixed idea which, instead of obsessing the mind, develops and becomes completely realised. An hysterical, described by M. Saint Aubin, dreams of her husband, who has just died. She enters a somnambulic state and goes to the cemetery as if going to bed, and falls asleep on his grave; she awakes without knowing how she came there. It is only in another somnambulic state—this time induced—that she can relate both her dream and her going to the grave. We have seen that Gib. thought constantly of her niece's death, and made a drawing of a window without knowing what she was doing, or wrote a letter to Pauline. At night, and later in the middle of the day, she allows this thought to take full possession of her mind; then she loses consciousness, no longer takes note of things, and gets up and runs to a window to throw herself out, as did her niece. A perception of surrounding things exists in

part, since she finds both the stair and the window, but the persons present she does not see. There is here a phenomenon of elective affinity for her magnetiser analogous to that of one in an artificial somnambulic state. In the same way Sm. took his pillow in his arms, got up in spite of his paraplegia, which disappeared at this moment, and fled to the roof, with the thought of saving his child; and he perceived the objects around only as they accorded with his dream. Besides, when they awake, both Gib. and Sm. have no recollection of what they have just done. They have to be put back into the somnambulic state in order to recollect the preceding acts.

5. *Complete somnambulism.*—M. Azam has employed this name to designate one of the psychological states of Felida.[1] It seems to be as justly applied to artificial as to natural somnambulisms.

We have had occasion repeatedly to establish this state with hystericals, and we have described it carefully, for we attach considerable importance to it.[2] Patients may enter directly, or oftener in consequence of somnambulic states analogous to the foregoing, into a particular state where their intelligence seems to take its greatest development. They recover the recollections of their whole life; they can relate their deliriums, their dreams, their preceding somnambulic states. This return of the memory is accompanied, as you may anticipate, by a restoration of all the sensibilities—of all the hysterical stigmata, anæsthesia, the retraction of the visual field; the troubles of motion have completely disappeared. In short, suggestibility no longer exists. The subject obeys voluntarily, but he no longer executes those automatic acts of which he had no consciousness. In a word, the

[1] Azam, *Hypnotisme*, "Double consciousness and alterations of the personality," 1887, p. 133.

[2] *Autom. psych.*, pp. 87, 105, 178.

personality seems completely reconstituted. It is a case of this kind which M. Despine described when he showed Estelle to us,—anæsthetic and paraplegic when awake, but perfectly sensible and running about on the mountain in her somnambulic state: "She has no other thought than to pick flowers and run about from ten in the morning till nine at night[1] in a somnambulic crisis."

Not to repeat the examples we have already published, we will consider only a curious observation, which may serve as a line of transition between artificial somnambulisms and second existences, which sometimes occur naturally. In 1887, M. Jules Janet, then house-surgeon (interne) at the Pitié, had occasion to study in M. Brissaud's service a young girl of twenty, often mentioned in this work by the name of M. This young girl, attacked for a long time with hysterical vomitings and retention of urine caused by spasm of the sphincter, had reached the last degree of weakness. All means had for a long time been employed, without any success, in enabling her to retain the least food on her stomach. She lay inert on her bed, wholly anæsthetic, and her limbs presented, when raised, partial catalepsy. M. Jules Janet succeeded in putting her into a state of very singular somnambulism, for in this state the patient could eat and make water without any difficulty. It was also remarked that, during this somnambulism, she recovered her sensibility and her limbs were freed from their cataleptic condition. The patient when awake threw up nothing of what she had taken in somnambulism, but fell immediately back into the state she was in before—that is, inability to take any food. She was, besides, again anæsthetic and showed complete forgetfulness of what had happened during the somnambulic sleep. It was soon necessary to put her again to sleep—to make her eat—and then awake her again. Despite all efforts, despite all

[1] Despine (d'Aix), *op. cit.*, p. 56.

suggestions, alimentation and micturition were impossible with her while awake. The patient seemed entirely cured while in the somnambulic sleep, but she was no sooner awake than she fell immediately back into her lamentable condition. They gradually then, and quite naturally, got into the way of leaving her longer in her somnambulic state, first a few hours, then a whole day, then several days, without waking her. She always woke completely oblivious of the somnambulic period, and with her anæsthesia and vomitings.

The mother of this young girl, seeing her one day in the somnambulic period, in which she always looked well, thought her sufficiently cured and asked to take her home. All went well for some weeks, but when the menstrual period approached, an unexpected thing took place: M. awoke completely and spontaneously, though as ill as before; besides, she had forgotten the whole of the month that had passed by, understood nothing, got frightened, and became delirious. There was nothing better to be done than put her back into the somnambulic state. They did so, and all accidents immediately disappeared. After that it became necessary to put M. back to sleep every month. M. Jules Janet did it regularly for some time. We ourselves took charge of this patient for three years. In fact, this young girl has now been kept five years in what we might call a somnambulic state. It was while in this condition that she made a living and passed quite difficult examinations. Her judges hardly suspected that they were examining a somnambulist. Is this term correct when speaking of such a case ?

It becomes so less and less. In fact, this word designates a state distinct from the waking state and opposed to it. Now, this primitive state, or so-called waking state, hardly exists any longer; it is rarely reproduced and that incompletely in a spontaneous manner. The patient becomes insensible, throws up a little, and forgets

a part of the foregoing remembrances. It is easy to put her back into a more complete somnambulic state. The waking state is no longer completely reproduced except when voluntarily induced by waking the subject. M. then is very ill and absolutely incapable of governing herself, for she has forgotten the five years that have gone by. We left her two days in that state to establish whether the oblivion was indeed real. The blunders of the patient with strangers, blunders which would have jeopardised the situation she had made for herself, forbade us to continue and repeat this experiment. Induced somnambulism became with this patient a second existence more complete than the first and became entirely substituted for it.

Facts of this kind have very often been produced in a natural manner. The stories of Felida, of Mary Reynolds, and of Hab. are well known. Most of these observations have been collected in the recent thesis of M. Laurent.[1] We shall remark only that with most of these patients there is a complete state during which anæsthesias disappear and memory extends over the whole life; in this state the patients are also more joyous, have greater energy.[2] It is usually this more complete state that is considered somnambulism, while the more incomplete is called the first state or waking state. Usually, too, it is the second state or somnambulic state which finally takes possession of the whole life. Felida and Mary Reynolds, now aged, remain altogether in this second state. Finally, with many patients, there takes place a mingling, a confusion of the two states. "With Felida the hysterical defects, which at first existed in only the first state, became also manifest in the second state."[3] With M., the sensitiveness we have just

[1] Laurent, *Des états seconds*, 1892.

[2] Weir Mitchell, "Mary Reynolds," p. 8.

[3] Azam, *op. cit.*, p. 101.

described, which was complete at the beginning, in the somnambulic state is to-day incomplete; the hysterical stigmata exist also to-day in the second state, but to a lesser degree than in the first. The somnambulic state is here a form of psychological existence, more or less complete and no longer a transitory accident; it allows us to understand the imperfect forms which we had at first observed.

It is almost useless to recall that these forms of somnambulism just described are types, simple cases which have been selected in order to permit the classification of the others. There exist between these different terms[1] a thousand intermediary forms, and the same subject may present, according to the manner in which the somnambulism is induced and according to the duration of this state, several of these different forms.

§ 4—INTERPRETATION OF THE PRINCIPAL PSYCHOLOGICAL PHENOMENA

One of the essential phenomena of somnambulism is forgetfulness on waking. This amnesia, we must remember, is of the same nature as all the other hysterical amnesias already described. Neither the preservation nor the reproduction of the images has disappeared; the question still is the disturbance of personal perception. The subject is incapable of connecting with his present personality the recollection of the somnambulic state; this is the essential factor. We have already seen how these disturbances in perception are analogous to diversions of attention; it needs sometimes but a suggestion, a slight effort of attention, for certain recollections of the somnambulism to be momentarily recovered. We have also seen how these disturbances depend on a permanent

[1] "Les phases intermédiaires de l'hypnotisme," *Revue scientifique*, 1886, i., p. 577.

retraction of the field of consciousness and on an enfeeblement of the psychological synthesis.[1] What we must study here is the particular localisation of this amnesia. Why does the subject forget regularly certain periods of his life, while he retains quite well the recollection of others ? We believe, moreover, as we have at length previously maintained, that we may give a general answer to this query. Somnambulism is forgotten because it is composed of psychological phenomena connected by association, collected around certain sensations, certain ideas even, which the subject can no longer perceive.

This explanation seems to us clear if we consider certain states such as complete somnambulisms. It remains, moreover, quite probable for other somnambulisms. Let us consider a subject like Lucy or Wittm., in complete somnambulism. They are persons absolutely normal, who present no longer any hysterical defect. They have an absolutely complete tactile, muscular, and visual sensibility; they walk and write without looking at either their hands or feet; they are in no wise modified by the closing of the eyes. Is it not natural to suppose that these tactile, muscular images, these movements executed by means of these images, play a rôle in their thoughts, connect themselves through synthesis with the ideas which they mean actually to express, are associated with all the events that are being produced ? Let us now look at those same subjects when out of the somnambulic state. After a time, half an hour with Lucy, several hours with Wittm., these patients complain of feeling uncomfortable, of being tired. If you do not interfere, their sensibility will diminish gradually, and all the hysterical stigmata reappear. They are now entirely anæsthetic, incapable of tactile or muscular sensations. This disturbance bears also on the images, since we see them

[1] *Stigmates mentaux des hystériques*, p. 91, above.

incapable of moving their limbs without looking at them, and present all the troubles of M. Lasègue's syndrome. The system of sensations and images which constitutes their personality is then no longer the same as it was a moment ago. It is not surprising that, predisposed as they are toward localised amnesias, they cannot consciously recover the remembrances of the previous somnambulic state. These remembrances are especially formed of tactile and muscular images which they now no longer can perceive, and of ideas associated with these images, and it is natural that they should entirely forget them. Amnesia depends here on anæsthesia and on the subconscious state of certain sensations and images.

The same interpretation may be applied to other somnambulic states less complete, in which the stigmata are not suppressed, but only modified. At each repartition of the sensibility there corresponds a general state of consciousness, a cœnæsthesia with which all remembrances are associated, and the memory of this period cannot be easily recovered without special suggestion and effort of attention, unless the subject is found again in exactly the same state.[1] If you will carefully observe this detail, you will discover, as we have often done, that, in all natural and incontestable somnambulism of hystericals, there are modifications almost always very appreciable in the repartition of the anæsthesias, and these modifications play, we think, a considerable rôle in the consecutive amnesias.

Let us proceed to somnambulisms still more rudimentary, those persistent, dominating, one idea states, in which the subject tries to kill herself or carries her pillow up on the roof. How can we understand that the patient on waking has forgotten all, even the things she seemed to perceive clearly? A few experiments may be brought to

[1] *Stigmates mentaux des hystériques*, p. 112, above.

the service of these facts. We suggest to Léonie that she has a beautiful black velvet dress on. This suggestion does not modify the general state in any way; does not change the repartition of the sensibility; it only induces an hallucination and changes slightly the attitude of the subject. Léonie sits up straight in her arm-chair with a serious face and a set smile; she hears us and answers us with affected gravity; in a word, she plays the part of a fine lady. Gradually the hallucination vanishes and Léonie resumes her simpler attitude and her plainer speech. If, at this moment, we make any allusion to the previous conversation, we see that she has forgotten all of it. If, several days after, we renew the hallucination of the velvet dress, Léonie takes up again the conversation at the point where she had left off, and recovers all the remembrances. Here we have an experiment of alternating amnesia and memory which was produced without somnambulism properly so called, and which may be reproduced in the same manner while the subject is awake or in a somnambulic state. How are we to understand her ? To our mind the recollections of the conversation are " crystallised " around a centre which is the hallucination of the velvet dress and the comedy of the fine lady; withdraw the centre and all disappears; restore it and all falls again into harmony. When Marguerite is angry with us she has remembrances which, the next day, when we are reconciled, she cannot recover, but which will all reappear the next time she gets again angry. This disposition is common with everyone. Now, a normal individual may, by an effort of attention, get out of the group of remembrances, awakened mechanically by the situation wherein he finds himself, but an hysterical cannot do so without assistance. If we consider our somnambulists with fixed ideas, we remember that with them the fixed ideas were already subconscious, isolated, outside of personal

perception. These fixed ideas become a centre around which a great number of psychological facts, apparently foreign, group themselves. Rah., of whom we have already spoken, has a subconscious dream regarding an attempt at a rape. She screams, jumps out of her bed, and runs into the garden. These are acts relative to the fixed idea (the rape), and we can understand how they can be forgotten as she has forgotten them. But in running into the garden she encounters a wheelbarrow, looks at it, allows herself to be suggestioned by the sight of it, and sets about hauling gravel. Now, this hauling of gravel is associated with the fixed idea of the rape. Awakening she does not remember either the one or the other; she has to be put back into her dream of the rape to find again her remembrance of the wheelbarrow. We have already pointed out some of these invading states which rob the subjects of the remembrance of the acts preceding somnambulism.[1] We see here that they take away the memory of the acts that follow upon the fixed idea. The subconscious character of the fixed ideas is here the starting-point of somnambulism and consecutive amnesia. It is easy to understand that, in all cases, forgetfulness on awakening is not always equally the same or equally complete. The forgetfulness which depends on a grave modification of the sensibility is far more serious than the one that depends on a subconscious dream; the attention, the efforts of the subject modify more easily the second than the first.

As for hemisomnambulism, it is likewise only a complication of these sensations, of these subconscious ideas of which we have so frequently established the importance. These subconscious phenomena do not seem to remain any longer isolated; they gather in groups, fall in with each other, complete themselves by robbing the normal perception of the phenomena, which were usually

[1] *Cf.* Pitres, *op. cit.*, ii., p. 195, and *Stigmates mentaux*, p. 110, above.

a part of it, and this ensemble has the appearance of more or less complete personality; it is a new form of psychological existence, no longer alternating with the first, but simultaneous and developing with it at the same time.

This factor of the combination, of the association of all these subconscious phenomena, the one with the other, is very general; it is that which allows the different somnambulic states of the same subject to group together, mutually to complete each other, and to form an entire psychological existence parallel to the first. Not only is the remembrance of preceding somnambulic states often established, but also the remembrance of the subconscious acts of the waking hours and even of hemi-somnambulism. Reciprocally does the automatic writing of a subject manifest the remembrance of both the other subconscious acts and of the complete somnambulic states.[1] This is what formerly we endeavoured to summarise in a scale which, with but few modifications, exactly applies to many patients (Fig. 11).

The foregoing facts will become more definite if we bring them close to the phenomena observed at the beginning of somnambulisms. How do patients enter the somnambulic state? In two different ways, both of which exhibit the same psychological fact.

1. Somnambulism begins often during a normal sleep, or during a sleep determined by suggestion, during a sleep induced by chloroform or ether.[2] It is brought about, with subjects, of course, predisposed to it, by fatiguing the attention, by continuous fixation; hystericals are, we know, incapable of a prolonged effort of attention; they get soon exhausted and become unable to retain the personal perception of the simplest phenomena.

[1] *Autom. psychol.*, pp. 334, 340, 410.

[2] Jules Janet, *Revue scientifique*, 1888, i., p. 620; *cf.* Laurent, *États seconds*, p. 38.

In short, several authors have dwelt on this fact, one of the most instructive. We know that many hystericals are disturbed when they are required to shut their eyes; their *voluntary* movements are altered, a vertical position becomes impossible, etc. With some, this disturbance goes much farther; not only are the movements of the limbs hindered, but those of the face become impossible; the subject, for example, can no longer put out his tongue (Baillif's sign); moreover, the thoughts have

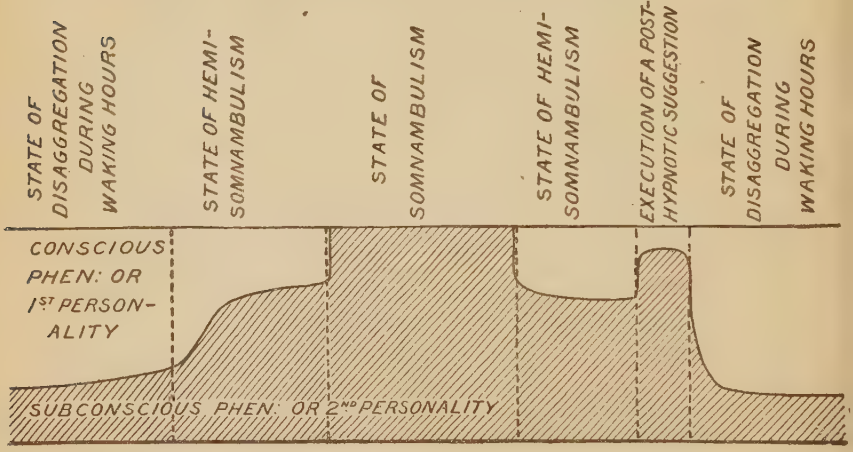
STATE OF DISAGGREGATION DURING WAKING HOURS
STATE OF HEMI-SOMNAMBULISM
STATE OF SOMNAMBULISM
STATE OF HEMI-SOMNAMBULISM
EXECUTION OF A POST-HYPNOTIC SUGGESTION
STATE OF DISAGGREGATION DURING WAKING HOURS
CONSCIOUS PHEN: OR 1ST PERSONALITY
SUBCONSCIOUS PHEN: OR 2ND PERSONALITY

FIG. 11.

become confused, and the speech is embarrassed.[1] Finally, among some the occlusion of the eyes or ears seems to suppress all the psychological phenomena. MM. Strümpell, Liégeois, Heyne, Ziemmsen, Raymond,[2] have recalled facts of this kind. The phenomenon is produced with a few patients completely anæsthetic, when

[1] Pick, Ueber die sogenannte "conscience musculaire," *Zeitsch. f. Psych. u. Physiol. der Sinnesorgane*, 1892, p. 185.

[2] Raymond, " De l'anesthésie cutanée et musculaire généralisée dans ses rapports avec le sommeil provoqué et avec les troubles du mouvement," *Revue de médicine*, 1891, p. 389, and *Bulletin médical*, 22 février, 1893.

the only senses by which they were yet in communication with the outer world are closed to them. To our mind, the state which is then produced is not a simple sleep; it may present psychological phenomena, more or less complicated, which will be forgotten later on; it is a somnambulic state. We see that somnambulism develops when, for some reason or other, normal consciousness, the first synthesis of the psychological phenomena, is suppressed.

Somnambulism may be developed in another way, namely, when, by the process of suggestion, by diversion of attention, by subconscious acts, by simply determining suggested hallucinations, the subject enters hemisomnambulism and gradually complete somnambulism. One may also start in the mind one of the phenomena associated with the group of factors which constitute somnambulism,—call, for instance, a patient by the name given him during a preceding somnambulism, show him one of the objects of which he dreams during his somnambulic state, provoke a sensation which, like a signal (*point de repère*), awakens the thoughts of somnambulism, and this second state is about to develop itself, more or less rapidly, and cause normal consciousness to disappear. We see also somnambulic states frequently develop in consequence of dreams, subconscious fixed ideas, or attacks. These facts show thus once more the existence of two series of phenomena in the mind, the alternation of which produces somnambulism and the waking state.

Up to this point we have considered only the outward form of somnambulism, the general laws by which sensations and remembrances are regulated. We should also take note of what the somnambulic state comprises, of the actions and words of the subject. We do not think that we can here lay down a general rule. The attitude, the behaviour of the subjects being things extremely variable, we should beware of taking for a general law an

individual movement. A certain hypnotiser is said to have declared that the subjects he put into somnambulic states always *thou'd* him, and that the fact of saying *thee* and *thou* to a hypnotiser was a sign of the reality of the somnambulic sleep!

To convince ourselves of this diversity among somnambulists, we would recall a few descriptions. Thanks to our researches and to the kindness of our friends, we were enabled to see a rather varied collection of somnambulic types of which a few were quite curious. First we place before you the somnambulist physician, Mlle. Eugénie, whom M. Ch. Richet had the kindness to introduce to us. We set out for the country in the suburbs of Paris, where Mlle. Eugénie lives in a small house and where we find her very busy with the humble functions of housekeeper. She is a very pretty young girl of twenty-two. She had been out all day giving consultations in a celebrated office, where she is assisted by a doctor, who signs her prescriptions. She has but just returned and is very tired, but she cannot remember what she could have been doing all day; she has completely lost the memory of all that happened since morning, but that does not trouble her, for she is in a hurry to prepare the soup for her aged parents. We get her to consent to our putting her to sleep for an instant. She is no sooner in the somnambulic state than the whole scene changes. With head erect she falls at once into the professional language; she says, authoritatively: "Imagine, my dear sir, thirty-one consultations to-day . . . and some very interesting cases. . . . I was quite right when I said that that lady was pregnant with twins; but her physician would not believe it, . . . all those physicians are but—simpletons!"

We come now to a somnambulist of the early days, one that recalls the old magnetism of Deleuze and Dupotet. It is an old lady to whom M. Gibert introduced

us. In her youth she had had hysterical accidents and was treated by magnetism. Hysteria and somnambulism seem to have disappeared long ago, but, on the occasion of the menopause, a few nervous accidents reappear and with them a disposition to somnambulism. Mlle. P. allows us to put her to sleep. What gravity and dignity in her somnambulic state! She is immovable, eyes raised to heaven; she speaks constantly of herself and of ourselves also, but in the third person; instead of saying, "I like you," Mlle. P. says, "She likes him; he is a good fellow." She obeys the suggestions of movement, but not those of hallucination. "He is master of her body, not of her soul." This is a sacerdotal dignity. We must not forget the scientific somnambulist. We had met, in the service of M. Powilewicz, an hysterical man, who had hung around various hospitals in Paris and who had come to wreck at Havre. We had put him to sleep and were examining, at too great length, perhaps, a contracture which had developed during the somnambulic state. S. seemed out of patience and murmured between his teeth: "These provincial students do not even know that a contracture is taken off by striking the antagonistic muscles. . . . Sir, should you like me to give you lessons on hysterical paralysis?"—"Thank you, good friend."

It is quite clear that, in these cases and in many others, surrounding circumstances, the speeches of people present, have, no doubt, even more than suggestions properly so called, furnished the somnambulist with an education. Suggestion does not create somnambulism any more than does anæsthesia. They may transform it and modify its outer aspect, that is all. "The moral preparation," as M. Briquet has already said, "is everything in such a case"; if you prepare your patients for convulsions, the somnambulists will have convulsions; if you prepare them for ecstasies, they will have ecstasies;

and, now that it is customary to produce somnambulic states, the magnetised patients, properly prepared, will be put into somnambulic sleep, and nothing else.'[1] M. Hack Tuke, in 1881,[2] explained many facts in the same way; most modern authors hold the same opinion.

This education only develops and models a psychological phenomenon already existent in the patients. We believe that one may also not explain, but summarise, a great many facts by the formula we previously proposed, namely: "If, as is natural, we put aside sleepiness, short naps, etc., produced by fatigue or ennui, in which one may encounter suggestibility as when awake, but which have but little relation to the somnambulic state, somnambulism is, above all, an abnormal state, during which a new form of psychological existence is being developed, with sensations, images, remembrances of its own, capable in certain cases of persisting on a second plane, after awakening, and of continuing under the most ordinary first existence."[3] The undoubling of the personality, so manifest in certain noted observations of double existence, exists in reality in the simplest of somnambulisms.

§ 5—RELATIONS OF SOMNAMBULISM WITH OTHER PHENOMENA OF HYSTERIA

Somnambulism is interesting not only in itself, but also because it is so intimately related to all the other symptoms of hysteria, and thus enables us better to understand them. If we consider somnambulism, properly so called, we soon observe that it almost always occurs with subjects who present an ensemble of symptoms belonging to hysteria. The hypnotisers, well acquainted

[1] Briquet, *op. cit.*, p. 413.

[2] Hack Tuke, "Hypnosis redivivus," *The Journal of Mental Science*, Jan., 1881.

[3] *Autom. psychol.*, p. 448.

with somnambulism, had already noticed it. M. Despine often dwells on it.[1] "The diseases of the nerves and hysteria," said also M. Noizet, "are the maladies which furnish most artificial somnambulists."[2] "We are indebted to M. Gendrin," remarks M. Briquet elsewhere, "for having called the physicians' attention to this fact, already so long known, that most somnambulists, called magnetic, are hysterical women."[3] Later, M. Gilles de la Tourette,[4] M. Babinski,[5] M. Blocq,[6] M. Laurent,[7] developing the teaching of M. Charcot, have enumerated all the hysterical symptoms that are met with in somnambulic patients. Many foreign authors have arrived to-day at the same conclusion. According to M. Strümpell, "hypnotic states and hysterical manifestations are at bottom closely united."[8]

For MM. Breuer and Freud,[9] "the hypnoid states and hysterical phenomena are closely united." "It is among the hystericals," says M. Donkin, "that we find the most cases of somnambulism . . . it is certain, from general experience, that human beings are hypnotisable in direct proportion to their nervous instability."[10] We should add, if our experience has some interest, that we have never witnessed any somnambulism, even when incomplete, without being obliged to establish, sooner or later, a whole ensemble of hysterical symptoms.

[1] Despine (d'Aix), *op. cit.*, p. 86 ; Despine (de Marseille), *Le Somnambulisme*, p. 140.

[2] Général Noizet, *Le Somnambulisme*, 1854, p. 187.

[3] Briquet, *op. cit.*, p. 413.

[4] Gilles de la Tourette, *Hypnotisme et états analogues*, 1887, p. 55.

[5] Babinski, "Hystérie et hypnotisme," *Gazette hebdomadaire*, juillet, 1891, p. 15.

[6] Blocq, *Gazette des Hôpitaux*, 23 janvier, 1893.

[7] Laurent, *op. cit.*, 1892, p. 159.

[8] Strümpell, *op. cit.*, p. 18.

[9] Breuer et Freud, *op. cit.*, p. 7.

[10] Donkin, article "Hysteria" *in the Dictionary of Medical Psychology*, of Hack Tuke, p. 626.

We have formerly [1] insisted upon another consideration which still more fortifies this comparison; it is that with many patients natural or artificial somnambulism disappears as the hysterical malady improves. M. Despine remarks of Estelle that the fusion of the two states of crises and non-crises (somnambulism and waking) increased insensibly every day." [2] Most authors who have described cases of double existence affirm that, towards the end of the life of these patients, the separation of the two states diminishes and unity is re-established.[3] We have already shown that when once hystericals are cured it is no longer possible to induce somnambulism; we have since established the same phenomenon many a time; it seems to us sufficiently characteristic. M. Charcot was, therefore, right when he said that somnambulism is a phenomenon which develops with hystericals.

If now we consider the particular phenomena which enter into somnambulism, we shall see that these phenomena are directly in relation with hysterical symptoms. It is useless to recall, what is evident, that post-somnambulic amnesia is an hysterical amnesia, absolutely identical with those localised amnesias which the patients constantly present. It is more interesting to observe that the double existence, the complete somnambulism, is a consequence of the hysterical stigmata. When we examine a subject of this kind, during this state, we establish that all his sensibilities, all his remembrances, all his movements, are absolutely normal. This state of complete somnambulism is simply the normal life, such as this subject would continually live if he were not ill. But he cannot stay in this state; he gets tired and falls asleep like Léonie or Lucy, or he becomes exhausted and

[1] *Autom. psychol.*, pp. 343, 446.
[2] Despine (d'Aix), *op. cit.*, p. 61.
[3] Weir Mitchell, *op. cit.*, p. 11.

delirious like Bertha, and, one way or another, falls back into a state of anæsthesia, of the retraction of the field of consciousness which constitutes his illness. It is this retraction of consciousness which brings about the amnesia of the preceding state, and it is this waking state which is abnormal and which transforms the moments of ordinary intelligence into somnambulisms.

To make our thought more apprehensible, let us take up again that story of M.'s, which we have already stated. It may be represented by the following diagram. Slowly, without its being perceived, this young girl grew worse every day; she had gradually lost sensibility and memory. We can represent this stage by a line which descends well below the line A B of normal intelligence

FIG. 12.

(Fig. 12). When she has been put to sleep in C, she rises again to a state of almost normal existence; through the effect of illness, she gradually redescends. At first she seems to awaken a little as soon as you leave her, and forgets what you have just now told her in putting her to sleep. Then, two days after, she wakes again, that is to say, she experiences a fall into a state of hysterical anæsthesia and amnesia still deeper than before; she forgets the two preceding days. Then she goes down again very slowly.

If you let her fall again or if you waken her in D there will be complete amnesia of the whole preceding period; if you excite her there will, on the contrary, be a psychological state far more complete and a perfect

remembrance of the preceding periods. It is those falls, those returns to anæsthesia, which give to the normal periods the aspect of somnambulisms.

With other subjects the somnambulic state is not directly determined by anæsthesia, but it is the development of subconscious phenomena, of dreams and fixed ideas, which have grown outside personal perceptions. Is not this again a characteristic of hysteria? There cannot take place here a second existence, incomplete like the first, except by development of phenomena which are outside the normal consciousness; and this isolation of certain thoughts is again a result of the pathological retraction of the field of consciousness.

A particular state, hemisomnambulism, has also the closest relations with the subconscious phenomena of hysteria. The automatic writing is possible only with individuals whose right arm is totally anæsthetic, or who are capable of an extreme distraction so brief that they know nothing of the movements of their right hand.[1] This anæsthesia and this absence of mind should not, however, suppress either the movements or the elementary sensations. An American author pointed out recently phenomena of achromatopsia which came upon a medium at spiritualistic séances.[2] Where will you find such characteristics if not in hysteria?

Finally, there exist hysterical phenomena the somnambulism of which comes still nearer; not only long periods of double existence, but states of duration quite short, during which the subject appears to walk or act automatically. These fugues of which he does not take account when he seems to awaken; these interminable reveries from which it is so difficult to withdraw him,

[1] William James, "Notes on Automatic Writing," *Proceedings of the American Society for Psychical Research*, 1889, p. 549.

[2] J. Edw. Purdon, "The Psychical Import of Variable Achromatopsia," from the *Transactions* of 1892.

and which he cannot explain;[1] these ecstasies, these catalepsies, more or less complete, etc., are but degrees or varied forms of somnambulism, reapparitions more or less complete of the second existence. Certain deliriums, even in which the subject cries, insults people, seems to play a part, are for us likewise but somnambulisms modified by special influences.

But one may go much farther, and M. Charcot long since established a notion which we consider quite essential for the interpretation of hysteria. This is the close relations which exist between the somnambulic state and the so-called hysterical attack. M. Charcot has shown that on one side the attack very often contained phenomena of a somnambulic nature, and that, on the other, natural or induced somnambulisms were often preceded or even accompanied by a great number of symptoms belonging to the attack. The subject continued in a subsequent attack the actions or dreams begun in the preceding. He had in his somnambulic state the same strangulations, the same contractures, as in the attack. In short, the proceedings which terminated or modified the one, equally succeeded in terminating or modifying the other.[2]

We think we have added some notions to this study made at the Salpêtrière. The subjects, we said, are capable of perceiving outward phenomena even during their attack; they pass very easily from the crisis to somnambulism and *vice versa*.[3] Memory, which is so important here, presents in these two states an essential characteristic—it is reciprocal; the patient, during the attack, remembers, indeed, the somnambulic state, and it is only

[1] Charcot, *Mal. du syst. nerv.*, i., p. 447; Paul Richer, *La grande hystérie*, p. 310; Pitres, *op. cit.*, ii., p. 235.

[2] Charcot, *op. cit.*, i., p. 447; Paul Richer, *La grande hystérie*, p. 310; Pitres, *op. cit.*, ii., p. 235.

[3] *Autom. psychol.*, p. 52.

during the somnambulic state that he recovers clearly the remembrances of the attack.[1] Here is, among many others, an observation which gives an example of these facts: When Bertha has her attack, we can stop her convulsions by putting our hand on her forehead. She recognises us, calms down, and talks with us; she has passed into the somnambulic state. Lately, a student in the service, finding her in convulsions, wished to try the same process. He put his hand on her forehead, but did not succeed in modifying the attack. He left the patient while in her crisis, and did not mention the incident. A few days later Bertha, whom we had put into the somnambulic sleep, related the affair to us quite spontaneously. No one had told her of it, but she had nevertheless quite an exact remembrance of it: "I felt clearly that M. X. had put his hand on my forehead."—"But then why did you not keep quiet?"—"Because it was not you." Modification of the crisis, perception during the attack, remembrance in somnambulism,—all the most important factors united here.

If we add that hysterical attacks can be induced in consequence of attempts at hypnotisation,[2] that attacks may be replaced by somnambulisms, that they may be modified by suggestions, by examples, by fixed ideas, like the second states, we shall be able to conclude in recalling the words of MM. Mesmer and Deleuze: "Most nervous maladies . . . insanity, catalepsy, are but an imperfect and degenerate somnambulism."[3] Somnambulism, then, is closely related to all the phenomena of hysteria.

We believe that we may be still more affirmative. Somnambulism is precisely characterised by the same

[1] "Actes inconscients et dédoublement de la personalité," *Revue philosophique*, 1886, ii., p. 590; *Autom. psychol.*, pp. 87, 120, 448.

[2] Georges Guinon, *Les agents provocateurs*, p. 29.

[3] Deleuze, *Histoire du magnétisme*, ii., p. 18.

phenomenon which is found at bottom of all hysterical symptoms—disaggregation of the mind, undoubling of the personality. Not only does it, indeed, coincide with hysteria, but, if one may thus express it, it connects itself by right with this malady. It is the same with subconscious writing, " medium " phenomena. These facts present in themselves all that is essential in hysteria.

It is well to agree on terms and to speak a precise language, even when one is in error. For us, this division of the personality, which is manifest with the somnambulist and medium, is precisely what we call hysteria, because it is found in all phenomena considered hysterical.

CHAPTER V

DELIRIUMS

ALTHOUGH most hysterical symptoms are the result of certain intellectual disorders, they do not generally constitute deliriums, so called. The perception of exterior objects, of social relations, seems to keep a sufficiently correct appearance to allow the patient to mix with every-day life. Illusions and dreams seemed to develop apart, and outside of consciousness, troubling it but little. "Hystericals," say MM. Breuer and Freud, "are reasonable when awake, and insane only when in their hypnoid state."[1]

Is this delicate distinction going to subsist always? Is it not likely that from time to time intellectual disturbances will grow somewhat, and sufficiently alter consciousness to trouble its relations, its "correspondence," with the outer *milieu* and social *milieu*, an alteration which will constitute a veritable delirium? Without any doubt deliriums are met with, and that very frequently, among hystericals, but their study presents a great difficulty. Are the deliriums accidental, consecutive to another mental malady, which may very well be superadded to hysteria, or are they the development of hysteria itself? The study of this question in respect to all deliriums that may present themselves would oblige us to

[1] Breuer et Freud, *op. cit.*, p. 8.

review the whole of mental pathology. In order to escape from this danger, we shall limit ourselves to describing the deliriums which seem to be the natural development of certain hysterical symptoms already known. We shall try afterwards to find out, in a general way, what place these deliriums should occupy in the malady of hysteria.

§ 1—EXAGGERATION OF ABOULIA—MENTAL CONFUSION

All hysterical stigmata depend, as has been seen, on a psychological insufficiency, which manifests itself by disturbances of attention and will, absent-mindedness, continuous amnesia, etc. It is true that generally the mental synthesis is much diminished, but yet not suppressed. The patient perceives but little, forgets much, acts badly, but, in a certain measure, he perceives, remembers, and acts. This weakness brings with it intellectual disturbances, absence of attention, doubts, undue astonishment before new objects, errors of memory, etc., but it does not generally reach what we call delirium.

This aboulia may grow at certain moments and manifest itself by intellectual disturbances much more pronounced. During the few hours that precede her attacks, and sometimes for a whole day, Marguerite appears stupid. She does not work, walks about at random, answers all wrong the questions put to her, and once, when we asked her name, she stood all in a maze and could not tell. She tries to understand and answer, and cannot; then she gets angry, stamps her foot, and gesticulates: "That is too bad! I can no longer tell my name . . . everything is getting mixed up in my head . . . do I dream? Now . . . what is it? . . . I don't know. . . . I think of a whole lot of things . . . my whole life is filing off before me. . . . What is it you want of me? How dark it is in my brain!" It

is not, as you see, a complete lack of intelligence, but it is a trouble of perception much greater than her ordinary aprosexia. We establish analogous phenomena with Bertha and Renée, with this difference, that, with the latter, this exaggeration of aboulia is rather manifested after the attacks than before. We can even prove with this patient delirious interpretations of her condition, which are particularly curious: "It is stupid," she says; "I scarcely dare mention it; I feel as if I were dead."

Another, Mus., who, in the same circumstances, is also unable to understand and reply, interprets singularly her condition: "I am silly, good for nothing. . . . I am like a criminal who is about to be punished. . . ." Here we are very near a delirium.

It is known that hystericals are, in general, very indifferent; they are fond of repeating past emotions, but they are incapable of forming new ones in harmony with their present situation.[1] M. Sollier insists on this idea of indifference with anorexic patients who do not eat enough. "This indifference exists not only in the intellectual, but also in the moral order; their families often wonder at their lack of demonstrativeness; they bear the announcement of the happiest or saddest events without ever manifesting any sign of happiness or sadness, equally indifferent to laughter or tears."[2] I have seen, under the same circumstances, this indifference astonish the patients themselves. "How much I have changed!" said Lec.; "I have not even enough strength left to detest my husband; one would say that everybody I ever knew has gone out of my mind." The absence of emotion so accompanies the absence of perception as to constitute a mental state approaching, more and more, insanity.

These symptoms may still more increase, suppress

[1] *Stigmates mentaux*, p. 205, above.

[2] Sollier, "Anorexie," *Revue de médécine*, 1891, p. 627.

well-nigh all mental synthesis, and throw the subject into a state of complete stupor. This state of *acute psych-asthenia* has been described under various names. To-day it is known, especially in France, under the name of "mental confusion." M. Chaslin has particularly insisted on the primitive mental confusion, which is produced almost of a sudden in a subject heretofore healthy, at least in appearance.[1] The mental confusion that takes place among hystericals is not of this kind, since it is only the momentary exaggeration of an anterior mental weakness. It has, however, we think, the same characteristics. A *résumé* of the following observation will give a better idea of this accident than a description.

Deni., aged twenty, presents sufficiently clear antecedents. Her mother was hysterical, had had attacks from fifteen to twenty-seven; her maternal uncle is eccentric and not very intelligent; her father died of pulmonary tuberculosis at thirty. This young girl had the measles in her childhood and a very serious typhoid fever at thirteen. Since that both her mind and her power of attention have remained very weak. She is a good worker, is even on the way of becoming an excellent milliner in an establishment where she is employed, but succeeds only by dint of enormous industry and application. "It is true," she said to her mother, "I am succeeding, but it costs me all too much. You have no idea of what I have to suffer in paying attention and trying to understand. It is not natural." This excess of work tells on her patience and self-command. In consequence of slight annoyances, she had two attacks of twenty minutes each, with contortions, lockjaw, and contractures. More recently, a few emotions, an attempt to seduce her, upset her. She came home very much agitated and talking wild about gentlemen who wished to run away with her,

[1] P. H. Chaslin, "La confusion mentale primitive," *Annales médico-psychologiques*, Sept.–Oct., 1892.

and of an expedition to England, where she was to have the management of a large millinery shop. She is not quite delirious, for the facts are true, but she complicates them and exaggerates them. After some days of similar agitation, she has again and repeatedly, an attack of convulsions and contractures. The family physician and M. Gilles de la Tourette diagnosed clearly her hysterical attacks. She was brought to the Salpêtrière, where we could examine her, two days after the last attack. The patient is in bed, immovable, very indifferent to what is done to her; she looks more surprised, dumfounded, than delirious. By insisting we prevailed on her to get up and follow us; she obeyed readily, and even stupidly, for she follows us everywhere, even when we leave the room for a moment. In examining her we cannot find *any hysterical stigmata*, but we discover the greatest confusion in her ideas and especially in her perceptions: "What has happened to me?" she asked in answer to our often repeated questions. "Why I do not know at all. . . . I was at the workshop, was working, how is it I am no longer there? . . . Where am I now? What room is this? . . . I do not understand; my head is empty. . . . You are really M. F., André's brother, are you not? . . . This lady [the matron] is Miss H., is she not? Am I, myself, still Deni.? Perhaps. But how very strange, I have forgotten everything; there is such emptiness in my head. . . . I am utterly gone. . . ." Complete aprosexia, with lack of perception, false perceptions, continuous amnesia, etc. The only fact which makes this observation more curious than the others is that this condition remained the same without modifications for two months and a half.

During this interval the patient has had now and then a few dreams, some having a vague connection with the incidents of the beginning; she was restless and cried:

"They are going to take me away very far. . . . I shall be a fine lady; I am Boulanger's daughter, etc."; the others, of a melancholy hue, resemble the interpretations of the false perceptions already pointed out: "Oh, dear me, how dirty I am! . . . you take my hands, you are not disgusted? Why do you look so sad? . . . I will not stay in a house where everybody looks sad." Once she was in a strange fit of anger; she was playing with a penholder she had found somewhere, and got it into her head to stick it into the hand of anyone that came near her; we had the greatest trouble in taking it from her. Now and then, especially when she became excited, she seemed to suffocate and set her teeth as at the beginning of an attack. All this, however, was very exceptional. On the whole, she was mostly immovable and very docile and sunk in a state of complete stupidity. Her health was good; she ate fairly well and did not seem to lose flesh; however, it is to be noted that towards the last of her illness she ate more and grew noticeably fatter.

Toward the end of the third month she had now and then during the day lucid intervals; she recognised people, remembered her former life,—not her delirium, however, nor her period of stupor, the recollection of which never came back to her,—she consented to work, to sew a little. In these fugitive moments we noticed that she was *hemianæsthetic on the left side;* this hemianæsthesia disappeared during the periods of stupor. We do not speak of the visual field; it has been, despite all our efforts, very difficult to measure, considering the character of the patient. She left the hospital half cured. We have learned since that the stupor has completely disappeared, but that the patient has still her crises of hysteria and fixed ideas, especially erotic ideas, as if there had remained something of the initial incident.

Left thus between symptoms clearly hysterical, this

mental confusion seems to connect itself with hysteria. This, however, should not surprise us; it is but the development of a psychological symptom, which we have met to a greater or less degree among many other patients. We are inclined to believe with M. Charpentier that phenomena of this kind are not in themselves very specific, and that they may be met with in the course of many mental maladies.[1]

§ 2—EXAGGERATION OF AUTOMATIC PHENOMENA—MANIACAL DELIRIUM

Hystericals dream very much during the night and even during the day. In attacks, in ecstasies, in somnambulisms, they play or talk their dreams. But these dreams have usually two characteristics: (1) They take place in abnormal states or subconsciously. They disturb the normal thought by diminishing the disposable force of attention, but they do not mingle with it. (2) They run generally on a small number of subjects, and these subjects are always the same. The dream may increase under various circumstances, become complicated in all its smallest incidents, and mingle with the normal perception. The patient, who, on account of her aboulia, is already incapable of clearly understanding things, will confound sensations, remembrances, and dreams in an inextricable delirium.

Let us examine the gradation of similar phenomena of hystericals who appear reasonable and are not considered delirious. They often present this exaggeration of a dream. Barb., who has left the Salpêtrière, retains a very lively recollection of it; she dreams of the hospital at night, and during the day she fancies meeting in the streets people she has met there, and stops to greet

[1] Charpentier, "La confusion mentale," *Révue générale de clinique et de thérapeutique*, 4 février, 1892.

them. Often, in the evening, or in the hours that follow an attack, Bertha dreams aloud. She, however, remains in a waking state, and mixes her dreams with her normal perceptions; she sees her parents dancing in the flame of the light; she tells them a thousand tales, and goes to climb up a column to get at "a fellow hanging up there." When you talk to her during one of these moments you will become aware of a very particular excitation. She moves about the whole time and talks with uninterrupted volubility. Her acts and words seem at first sight absolutely disconnected and incoherent. They are, in fact, determined by all the little impressions which strike her senses and by all the associations of ideas which they determine. There is no effort of attention to stop a sensation, to choose a series of ideas; it is pure automatism of all the images that run into each other, interrupting each other reciprocally. It is the telegraphic language of the maniacs of which MM. Falret and Magnan speak:[1]

Oh! that pink paper! I am going to make a dress for my doll; I used to take her with me always a-travelling; Saint-Cloud is not so nice as the seashore. Oh! that string there! let me pull the mechanism; how now! what have you in this bowl? It is my aunt; my, how ugly she is! . . . This lady looks as if she were coming from confession. You know I never go there. . . . How many flies here! they have large wings with diamonds on them; oh! Maxime! he is as lively as a snail; look at his horns, etc.

This chatter lasts for hours; all this while she is not exactly without consciousness of what she is doing. She recognises people, she listens to us somewhat, and minds us for a minute if we speak sternly; she knows that she is absurd, and promises to behave better; but she begins

[1] Magnan, *Leçons cliniques sur les maladies mentales*, 1873, p. 386.

over again in a few minutes. A rather singular fact may be observed in regard to Bertha's excitation, namely, that this state, more or less serious, is prolonged for several days and alternates with a state of mental confusion and sadness which lasts a fortnight. It would seem that, being an hysterical, there is here an outline of circular delirium.

With other patients, this same state is still more pronounced. P., twenty-five years old, had usually short attacks. She has not had any for a month; but she is continually, day and night, in a state of agitation worse than Bertha's. Celestine's excitation is more dangerous, for the patient is constantly in a state of hallucination. She hears people insulting her and sees men and horses fighting and bleeding; she clenches her fists ready to strike. This delirium does not last very long. It ends in the course of an hour with the attack. Merc. was chloroformed for a small operation. She woke all dazed and full of laughter. Since that she has been for three weeks in a state of excitation, not exactly delirious, but dreaming aloud and talking all the time; she does a thousand queer things and cannot succeed in either keeping still or sleeping. As a detail to be mentioned, she can, like Bertha, be put to sleep by suggestion, even in the midst of her excitation. Her automatic reveries are also stopped by suggestion; they return, however, after a few hours. Let us observe that, with the preceding patients whose excitation may yet be arrested and regulated, hysterical stigmata persist. On the other hand, the delirium is momentary; it disappears like an attack. It will not be the same when we come to the study of more serious accidents.

We often meet hysterical deliriums quite permanent among children.[1] M. Jolly has recently dwelt upon these little patients who commit all manner of very foolish

[1] Gilles de la Tourette, *op. cit.*, p. 545.

things and seem to play a farce before their frightened parents.[1] A number of authors—Briquet, Marcé, Morel, J. Falret, Grasset, Krafft-Ebing, Schüle—have established that hystericals, even adults, can have deliriums of a maniacal form, deliriums quite prolonged and without any precise relation to the attack. Let us first establish the facts before we try to interpret them. Par., seventeen years old, presents serious hereditary antecedents: maternal grandmother hysterical, maternal granduncle insane, mother and father hysterical, paternal aunt eccentric and obsessed. In her childhood Par. was very gay and lively; she looked intelligent, but learned with great difficulty. When, at the age of fourteen, she had her menses, she became indifferent and sad; she seemed preoccupied and grew more and more incapable of understanding and remembering what she was taught. At sixteen she caught a nervous cough, which never stopped, day or night, and which, with a few remissions, has lasted over a year. This year, in consequence of an emotion and a few slight annoyances, she was taken with pains in the stomach, vomitings that could not be checked, and convulsive attacks. From time to time she was beside herself—talked nonsense; the least thing scared her; she trembled, said they were going to cut off her head, that she must run to the neighbours for safety, etc. The physician who examined her at the time declared an hemianæsthesia on the left side, and succeeded in hypnotising her; he could make suggestions to her and calm her for some time. The convulsive accidents disappeared, and the delirium increased. Her friends decided she should be taken to the Salpêtrière.

Here is the case of a little young girl who at first appears intelligent. She does not seem delirious, understands the questions put to her, and answers pretty well. We cannot discover any hysterical stigmata and have

[1] Jolly, *Ueber Hysterie bei Kindern.*

never been able to see in her either a somnambulic state or any subconscious act. That which seems to characterise her is, that she constantly mingles, with her sensible acts and words, absurdities and dreams. She will not let me look at one of her arms, around which she has sewed a black ribbon, " to prevent her being crucified." She stops in the midst of a phrase, shuts her eyes, and puts out her tongue; or, again, she will stop answering altogether, and repeat one word, very fast and indefinitely: " I am hungry; . . . I am sick," or she recites a fable. All at once she lies down on the floor and begins to undress. When she is lying in her bed, she comes out of the sheets and evacuates—soiling her coverlet—right in the middle. For whole days she takes on some tic: sucks her lip, or puts two fingers crosswise, refusing to stir them. Lastly, when left to herself, she is in constant motion, chatters indefinitely, repeating for hours the same phrase in an emphatic tone, such as " I have an insurance, I have an insurance against life, against death." To end the observation, we must say that this condition has lasted without any great modification well-nigh seven months. Now and then the patient for some time appeared cured, but showed little intelligence. A second paroxysm of the same sort brought with it rapidly a state of intellectual enfeeblement, which may be considered a forerunner of precocious dementia. This fatal termination fully agrees with the teaching of our excellent master, M. J. Falret, who considers this kind of delirium, usually described as hysterical delirium, as very serious and of much darker prognosis than is generally believed.

We notice in the preceding observation most characteristics which alienists like MM. Moreau (of Tours) and Falret have described in the hysterical mania, " a delirium which bears on the actions more even than on the words; varied impulsions; a sort of ambulatory automat-

ism rather than an inco-ordinate agitation"[1]; extravagant actions seemingly done on purpose to call attention to them. At the same time a rapid succession of various reveries, inspired by the surrounding facts or connected with some dominant obsession. Par.'s habitual subjects were especially religious preoccupations; other patients, as has been remarked, were, above all, given to erotic preoccupations; but all this is of a very variable character. We should, however, note a difference. This patient (Par.), at least during the time we examined her, did not seem to us to have very clearly distinct hallucinations. Delirious hystericals, as we have seen by the preceding examples, have, on the contrary, particularly lively hallucinations of all the senses, and it is in the hysterical delirium and in the toxic deliriums that visual hallucinations are the clearest. Other characteristics are, on the contrary, conformed to the classic description. The patient is conscious, in part at least, of her condition,[2] and complains of her head being empty; that she no longer understands very well. "I am no longer what I was; my head is gone." She is incapable of any attention and has hardly any memory left. These are characteristics which recall in a certain vague way the preceding hysteria. A state like this is, as we have seen, connected with hysterical phenomena, but it indicates evidently a considerable transformation of the malady.

§ 3—EXAGGERATION OF FIXED IDEAS—SYSTEMATISED DELIRIUM

Fixed ideas, so frequent and of such importance among hystericals, are generally isolated in their minds. Whether they constitute attacks, or develop in a subconscious manner, they do not disturb the whole thought of the

[1] Sollier, *Guide pratique des maladies mentales*, 1893.
[2] Régis, *Manuel de médécine mentale*, 1892, p. 490.

patients. Yet it is easy to understand how the neighbourhood of these fixed ideas, these parasites, may be very dangerous to normal consciousness, and that in many circumstances general disturbances of the whole thought may be the result of the development of fixed ideas.

Already, under the simplest of circumstances, the hysterical may remain several days obsessed by recollections more or less vague which subsist after the delirium of the attack.[1] M. Charcot relates the case of an hysterical who, after a crisis in which he thought he had been bitten by animals, examined his arms to find the traces of the bites which he believed he had felt.[2] M. Colin relates also the case of an individual who bit his own hand, and, not able to believe it, and thinking he was bitten by a mad dog, went to M. Pasteur.[3] Many patients commit thus various absurd acts in consequence of an attack or a dream. Maria goes to the morgue with Mme. D., who insists on entering the amphitheatre because she had dreamt of a suicide. These as yet are but isolated acts, but already irrational.

Things become worse when we establish a general modification of the moral state, of sentiments, and cœnæsthesia. Some patients suffer from sadness, from melancholy states which they cannot explain and which result in fixed ideas. Here is a fact now which is not absolutely spontaneous, but which is very clear. We had induced somnambulism in Mme. D., trying to modify one of her fixed ideas; she resisted greatly, and to overcome her objection we pretended to get angry and declared that we would no longer have charge of her. This little scene had at first a good result, for she became more docile, and when we woke her she was quite calm. Three days later we learn that Mme. D. is all wrong

[1] Gilles de la Tourette, *op. cit.*, p. 495.

[2] Charcot, *op. cit.*, iii., p. 262.

[3] Colin, *État mentale des hystériques*, 1890, p. 30.

again. She cries constantly, moans, is incomprehensibly anxious, and when people attempt to console her she replies: "I don't know what is the matter with me. I am in despair as if some misfortune had befallen me, as if I had committed a crime. What is it that has happened to me?" It is enough to put her to sleep again to establish the part which the subconscious recollection of the foregoing scene played in this despair. Reconciliation during the somnambulism caused all these notions to disappear.

Facts of this kind very often occur naturally. It was the remembrance of his wife which produced, without his being aware of it, his sadness and even the mutism of Pasq. It was the obsessing remembrance of her mother which called forth the despair of Bertha. We have already, in speaking of the fixed ideas, alluded to Isabel's remorses. When M. Charcot describes to us a case of traumatic hysteria, as "gloomy, almost stupid,"[1] we are disposed to believe that it is a case of the same kind. This melancholy may be added to the doubts and amnesias which fixed ideas would already provoke; but here the phenomenon comes nearer delirium.

The trouble may be still more grave and modify not only the sentiments, but the intelligence itself and the whole conduct of the patient. Let us, in this instance, go back to certain modifications of the hysterical character which appear to us wholly due to the mistaken existence of some fixed idea. We have refused to consider lying as a general stigma of the hysterical mind, but we admit its existence in certain cases. Here is an observation which, we think, gives us to understand how it may sometimes present itself. A young woman, Gab., twenty years old, and already hysterical, had allowed herself, in consequence of rather particular circumstances, to deceive her lover. Soon after she experienced great

[1] Charcot, *op. cit.*, iii., p. 455.

remorse and resolved to do everything in her power to conceal from him her fault, a thing which, at the outset, was easy enough. But from that moment there took place in her mental state two modifications. First she lost a special sense which she had heretofore possessed, and became entirely cold—indifferent. Then she began to dissemble in all her conduct. From day to day she lied more, first, when speaking to her lover, then even in speaking to strangers. Everyone that visited her perceived it with great surprise, for they had never detected this vice in her. She lied continually even about most insignificant things, even to the concierge of her house, who thought her crazy. One day she could stand it no longer. In the midst of an attack of cries and sobs she confessed all to her lover. She was pardoned, and from that moment Gab., as by miracle, recovered the sense she had lost, and never again uttered the smallest lie. Another patient, H., has lied ever since she has been married. Is it because she is hysterical? But she has been hysterical a long time, and was not given to lying before her marriage. It is because she tried and still tries to dissemble the hatred she entertains for her husband, and this hatred proceeds from the fact that on the night of her wedding she caught a blennorrhagia from him. This is the medical truth. M. Krafft-Ebing, when he denied the general character of simulation attributed to hystericals, showed also that the inclination to lying and in some cases to stealing depended on quite accidental circumstances.[1]

M. Jolly analyses likewise very correctly lying in hysterical children. He shows how in childhood a natural disposition to lying develops on occasion of a fault from fear of punishment.[2] The lying of hystericals, when it is

[1] Krafft-Ebing, *Eine experimentelle Studie auf dem Gebiete des Hypnotismus*, 1893, p. 4.

[2] Jolly, *Hysterie bei Kindern*, p. 9.

not an individual vice or a mistake of the physician,' is for us a systematised delirium induced by a fixed idea.[2]

The same concerning erotism. It is met with very rarely, it is true, but it may be extremely dangerous through the acts and denunciations with which it inspires patients. It is a special delirium, the starting-point of which it is not always impossible to find. Cher. belongs to a family singularly predisposed to mental disturbances: father eccentric, obsessed, alcoholic; paternal aunt an idiot; mother hysterical; maternal grandmother insane; two maternal uncles dipsomaniacs. Cher. is the last of fifteen children of whom the first seven died young in convulsions, the eighth insane and a lunatic, the ninth an idiot, the tenth hysterical, the eleventh a neurasthenic, the twelfth dipsomaniac, the thirteenth and fourteenth the same, the fifteenth, Cher., hysterical. The latter already presented, from the age of fifteen to twenty, all the possible accidents of hysteria. Upon soil thus prepared, the slightest accident will give rise to a fixed idea, which will quickly invade all consciousness. A young man spoke to her in a very proper manner, since he asked her in marriage of her father. This is enough; now she is preoccupied: "She reports of being improperly handled; spider's feet are drawn on her abdomen; shocking things are said to her, and before her; things are done . . . that should not be done; after all she is resigned; she is going shortly to give birth to a dirty infant through the anus and to another through the side; and then she will be guillotined, and the hospital to which she is being taken is a prison. . . ." This patient has more hysterical stigmata easy to establish. With many women the least amorous preoccupation brings with it a language and indecent attitudes, often observed and established in the case of young

[1] Charcot, *op. cit.*, iii., p. 432.

[2] Cf. *Stigmates mentaux*, p. 216, above.

brides. With the hysterical the preoccupation grows into hallucination and delirium.

Among these deliriums, the most frequent and those which have for the patient the most fatal consequences, are those which induce the refusal of food and which are often classed under the somewhat vague name of anorexia or sitieirgia.[1] The deliriums which bring about this result are very varied and would require a special study, which we cannot make here. Isabella refuses to eat because she has a subconscious remembrance of the delirium of the attack, Marcella, because during the attack she heard an inner voice forbidding her to eat. We have seen a young girl, Br., brought too late to the hospital to be saved, die of hunger because she had dreamed too long "about the bad turnips in her boarding-school." Finally, there remains for us to dwell on the ideas of hatred and the ideas of persecution, which can develop even so far as to form great deliriums with chronic evolution. Here is the fragment of a letter which Th. wrote to one of her friends:

> There is perhaps no suffering more horrible than mine . . . I should like to love my daughter, and I have loved her, adored her, and now I cannot; it is impossible for me. I dare not express it thus; I hate her. Oh! do not despise me for it. I know quite well that these are not the feelings of a mother. I try to repel them, but I cannot; on the contrary, this hatred seems to have rooted in my heart. . . . A mother who does not love her child is a monster. . . . Poor little creature, I should like to love thee, and thou art for me but an object of repulsion.

All this was caused by a quarrel between Th. and her husband on account of the mother-in-law; the little child was detested through association of ideas. Th., reconciled to her husband, recovered all her maternal

[1] Sollier, "Anorexie hystérique," *Revue de médecine*, 1891, p. 629.

sentiments. It has been observed that hystericals detest among their children especially the one that most resembles the father. This is not a trait of the hysterical character; it is a frequent accident because of the conditions of the conjugal life. With whom is a woman more disposed to quarrel than with her husband ?

Sometimes incidents of this kind among patients lead to ideas of vengeance, more often to dreams of persecution. We have already repeatedly established them with Bertha; here we find them with other patients. Is. can no longer tolerate little children; she pretends that they torment her continuously and she repels them furiously; she leaves her family and makes herself another home, in order not to meet with children. It is the result of a dream absolutely subconscious, consequent upon her clandestine confinement, as it may easily be verified by putting her into the somnambulic state. Marcella, especially when in her crises, dreams: " My brothers do not love me . . . my mother is not my mother, my brothers are not my brothers; they have shut me up in order to rob me . . . etc." [1] Mar. moans in a more monotonous manner because " everybody dislikes her, everybody despises her." There is always some little incident in question which was the germ of a delirium. Many authors have pointed out in hystericals ideas of persecution of this episodic style. M. Séglas describes in particular a patient who explains all her pains as due to hysterical hyperæsthesias, as arising from priestly persecutions and the poison she had been made to take.

Yet, with all these patients, as we formerly remarked, " the ideas of persecution have by no means the coherence and cohesion they have with people really persecuted. When Marcella speaks of these ideas while in a somnambulic state, she affirms them stubbornly, but can nowise explain them. She does not invent any

[1] " Aboulie et idées fixes," *Revue philosophique*, 1891, i., p. 278.

reason in explanation of this universal hatred, and a few moments afterwards, without minding contradiction, she says 'that everybody in the hospital likes her, and that everybody is very kind to her.'" She does not appear herself to understand the value of such phrases. "You, too, you are angry with me," she said to us.—"You think I am going to hurt you?"—"No; I know quite well that you are not."—"Are you afraid of us?"—"Why, no! since I come along with you, quite alone and don't care."—"Then, what do you mean by saying that we are angry with you?"—"I don't know." "These notions during the crises are not accompanied with pride, as would be the case with people really persecuted, or with humility, as with melancholy people; the patient just establishes that universal ill-nature as a fact she is helpless against, or rather does not connect the idea with the ensemble of her other thoughts. She accepts the notion as some strange thing like the medium who does not apply to himself the divagations of automatic writing."

We believe, however, that rarer cases may be met with, where the diagnosis becomes far more delicate, and the following observation is particularly interesting from this point of view: Bans., whom we studied in M. Hanot's service, presents himself at first in the following manner. He is a man of thirty-three years, short, deformed (anchylosis of the right knee and atrophy of the thigh in consequence of a white swelling). He complains and constantly demands things in a tone half persuasive, half arrogant, ready to get angry if you do not grant him what he wants. "I want my tea; I want a chair; I am ill-cared for; it is the fault of the overseer of the service. Besides, it is always so; they all provoke me; annoy me about trifles, always try to avenge themeselves simply because I will not mind their taunts; I am crucified by the women." He repeats constantly and describes with

complacency all the tortures the women cause him to endure; how they electrify his organs, and put under his nose "cow dung, the worst stench there is." If you ask him the reason of such tortures, he becomes excited and begins on grand declamations. "There is no longer any religion, any justice, any conscience; one must expiate the sins of the world and I carry the sins of the world; the women persecute me because I am the victim designated by the Gospels. An angel told me so, and still tells me: 'I tell thee in truth; remember my words; thou shalt be like God; thou shalt know everything and thy kingdom shall come at the end of the eighteenth century'" (*sic*). In reality one is to understand by all these big phrases that he is Jesus Christ, come back to earth at the time of the great corruption, as the Scriptures say. The moment is well chosen, when darkness shall cover the earth, and, indeed, we have this year evidently a sad time. Jesus Christ is to go from Jericho to Jerusalem, a metaphor implying that he will come from Châlons to Paris, as he (the patient) did. He alone has the right to speak to God his Father and to converse with the angels; already in the womb of his mother, he remembers it very well, he heard the angels predict to him this high destiny.

Is not this almost completely the picture of the great chronic deliriums? Is it not a variety of the delirium of persecution complicated with erotic and mystic delirium? The complete systematisation of all the little events connected with delirium—pride, and hypertrophy of the ego, the hallucinations of the hearing,—is found there very clear. It is true we notice a few extraordinary details, hallucinations of all the senses and even of the sense of sight, the latter in small number and not very clear. He remembers having seen angels, but he does not mention any time. We may also, though rarely, show him the contradictions of his delirium, and make him hesitate a

moment. These characteristics may be met with even in the deliriums of persecution.

But if we go back to the origin of this delirium, our opinion will be greatly modified. Far from being of long standing and dating its origin from troubles of character existing since infancy, this delirium is relatively recent; it arose some few years past in consequence of very different accidents.

To sum up the history of this patient. His mother does not seem to have presented nervous accidents; his father, on the other hand, suffered from crises of suffocations (?), and his paternal aunt was insane (nervous attack and erotic ideas); Bans. was raised by priests amid religious practices; he was sickly, and not very intelligent; at the age of eight he had a tumour, probably tuberculous, on the right knee, which rendered him infirm. At fourteen he was sent to pasture the cattle in the mountain, and he remained whole days alone, dreaming. At that time he acquired the habit of masturbation, to which he soon attributed an extraordinary importance. He wrapped his organs up and studied them constantly; he experienced the strangest sensations and was not long in ascertaining the varied troubles of urination. A few attempts at a normal copulation were wholly fruitless, and at twenty he presents a complete picture of urinary and genital hypochondria, such as has recently been described by M. Guyon.

At that time a new accident overtook him. The masturbations, more and more painful, were accompanied with anguish, suffocations, and convulsions. The penis became the starting-point of the aura, which ascended into the belly and smothered him in the throat. At the moment of the ejaculation he fainted and fell into convulsions. But soon, remembering the lessons of his first masters, he declaimed, preached about the vices of the time, and the catastrophes prophesied by the prophets to

impious nations. The crisis terminated with a prolonged sleep and involuntary emission of urine. At last the patient ate a big piece of bread, "to make the ball go down." This attack, clearly hysterical, comprising a religious sermon within an ejaculation and an involuntary micturition, is already in itself rather curious. Towards the age of twenty-five, things became still more complicated. On recovering from a great crisis, he remembered having seen an angel and having heard words which charged him to save humanity and defend it against the women. The question probably is of some hallucination that came upon him during the delirium of the attack. It can hardly be stated exactly at the present day. At any rate, he took to meditating over the fact; soon the attacks disappeared, hallucinations took place when he was awake, and the delirium developed in all its completeness.

To-day it is fully systematised, and seems to have suppressed all the other phenomena. The patient has no longer any attacks, no longer yields to masturbation, has no longer any urinary troubles. He has, however,—and this is an important detail,—retained some traces of stigmata. Without being insensible, he is strongly hypoæsthetic (90 by the æsthesiometer applied to the inner surface of the wrist), the visual field retracted to 60°. The patient pretended that he had but a short time ago been unable to distinguish the food he ate; he thought he was chewing sand. To-day taste and smell are normal. It would seem that the hysterical stigmata are also disappearing, and that the systematised delirium will more and more take completely the place of all the hysterical phenomena. This is evidently a case which is far more complex than the preceding ones, and which would require much longer study. We have made a résumé of it to indicate the great development which systematised deliriums will take with hystericals.

§ 4—RELATIONS OF DELIRIUM WITH THE OTHER PHENOMENA OF HYSTERIA

The deliriums we have just described have given rise to many controversies, but their nature, their interpretation, are far from being clearly established.[1] There is certainly in this matter an obscure problem, the solution of which depends not only on the studies of hysteria, but also on all the other theories relating to deliriums in general and to insanity. The classification of the mental maladies is still so indefinite, involving so many contradictions and obscurities, that a certain indecision in speaking of deliriums, particularly complex ones, must appear excusable. Let us, then, begin by indicating the points which appear clear to us, in order clearly to demonstrate, next, the nature of the questions which, to our mind, should still remain pending. It seems to us incontestable, and, besides, it is admitted by all authors, that deliriums exist among patients considered hysterical. These deliriums may present themselves, as M. Krafft-Ebing has shown, under the form of transitory attacks, of deliriums prolonged in the interval of the attacks—in short, as psychoses, chronic and definitive.

We have established examples of these three forms with confirmed hystericals. There results, from a practical point of view, that we can count these deliriums among the possible, and even probable, accidents with the patients we are occupied with. Secondly, it may be asked: Have the hystericals who present these deliriums, personally or in their anterior illness, something particular about them which especially predisposes them to that accident? May we give them a special name beforehand—call them, for instance, degenerates, in opposition to other hystericals who are not degenerates? We do not believe that this special character exists. Hystericals

[1] For the historical facts of these discussions, *cf.* Colin, *op. cit.*, p. 67.

predisposed to deliriums have always been diagnosed after their delirium; previously they were confounded with the others. Hereditary antecedents are exactly the same with the two categories of hystericals—with those who are delirious and those who have contractures. The signs of physical degeneracy, if any importance is attached to this, are met with in both. As to suggestibility, to disposition to obsessions, to fixed ideas, this engenders delirium, it is true, but it also engenders paralyses and attacks. They are a fundamental characteristic of all hysteria. Deliriums may, therefore, develop with hystericals, and strike whatsoever hystericals that were not designated as such. Here, then, are two points which seem to me indisputable, and which practically are most important.

In what way should we consider these deliriums? Should we consider them as an accident of hysteria or as a wholly different malady, superadded to hysteria? The question is certainly a delicate one, but it is, after all, a question purely of words, and the solution will necessarily vary according to the sense each author will give to the term *hysteria*. Mental diseases are, unfortunately, not so clearly characterised that there can be no hesitation regarding their limitations.

Certain authors have adopted on this point a very categorical and simple opinion. They consider hysteria as a disease with physical symptoms, quite distinct from mental diseases, and consequently in itself incapable of producing deliriums.[1] So, when they are obliged to establish deliriums with hystericals, they connect them with another malady quite different, which they designate in a rather vague manner by the name of delirium of degenerates. This opinion has been especially maintained in France in the very interesting thesis of M. Colin.[2]

[1] Féré, "La famille névropathique," *Archives de neurologie*, 1884, ii.
[2] Colin, *Essai sur l'état mental des hystériques*, 1890.

While recognising the importance and value of the observations contained in this work, we think that it would be possible to interpret them differently.

A disease is not an immutable entity, easily recognisable. It is a classification of symptoms grouped for the convenience of our mind. Hysteria is but a syndrome, an ensemble of facts grouped in a general idea, which facts are nearly all moral facts; they are somnambulisms, attacks, fixed ideas, disturbances of the attention, forgetfulness, insensibilities, which are psychological phenomena. There is no valid *a priori* reason to refuse to bring within this framework deliriums that are simply other mental phenomena. Besides, these authors themselves scarcely apply their doctrines in their extreme sense, for they accept the delirium of the attack, and even anorexia, which is, to a supreme degree, a delirium of long duration. We may, then, consider certain deliriums as hysterical.

But should we for this reason fly to the opposite extreme, and affirm that all the deliriums that present themselves in patients having or having had a few stigmata, should be included within the range of hysteria? This inclusion would find great inconveniences. Some of these deliriums do not differ from others which befall equally non-hysterical people. Must all these innumerable phenomena be connected with hysteria? That would altogether confuse the analysis of the symptoms of hysteria. We should select among all these accidents those that come within our conception of hysteria.

This selection is extremely difficult, but it is an ideal which science should endeavour to realise, but which nowadays is far from being always possible. In order to be able to do it, we ought to recognise two characteristics in a delirium: (1) Is this delirium the consequence of a clearly hysterical phenomenon? This first characteristic is important; it allows us to eliminate febrile

deliriums, toxic or otherwise, which hystericals may have in common with other patients. We have repeatedly shown that the delirium was, in the case of certain patients, but the aggravation of an anterior symptom. But this characteristic is far from being sufficient; for, to our mind, an hysterical symptom may by aggravation be completely transformed. (2) It would be necessary, even in delirium, to establish the fundamental character of the mental state of hysteria: the undoubling (*dédoublement*) of the mind, the alternation of the states of consciousness, the formation of phenomena really subconscious.

In some cases this characteristic will manifest itself by phenomena analogous to the attack or by the preservation of the stigmata. But this is not often the case, for hysterical stigmata disappear during delirious states, as during states of somnambulism, drunkenness; hysteria, as M. Morel said, becomes larval (*larvée*). They are then, as we have shown, delicate and flitting symptoms, which disappear as soon as the mind is disturbed. Therefore this proof which we ask is extremely difficult to give in most of these cases, although it is sometimes possible. Many patients, whom we have described, continue to enter into somnambulic states and even, during their delirium, present automatic writing, and we establish by these means the ideas, the recollections, unknown to the subject himself, which induce and keep up the delirium. An observation, very curious, we think, which deserves to be studied more in detail, will give us an example of a delirium which preserves its hysterical character to the end.

Daill., a man of thirty-three, is brought to the Salpêtrière in November, 1891, in a lamentable state. His face is covered with blood and dried-up clots, for he tears his face with his nails; his eyes are haggard, his lips cracked; he cannot walk, unless accompanied and closely watched. When he is left to himself he tries to run

away, and he has already committed a thousand crazy acts. He threw himself, for instance, with his feet tied together, into a marsh; he goes to sleep on the graves of the cemetery. He answers badly to any direct question, but we understand his delirium in the midst of his divagations. He sees the devil before him, all black, with horns and a grimacing face; he hears a demon whisper in his ear threats, curses, and pernicious counsels, such as: "Drink champagne; the end of the world is at hand." He feels another demon in his breast, who obliges him to utter blasphemies. As you see, they are hallucinations of all the senses, complicated by an impulsive delirium and by delirious interpretations. It is a fine delirium of possession with subacute maniacal agitation.

And yet we think we can demonstrate in this case that it is a question of real hysterical delirium. We shall not be led into this belief by the stigmata. The patient seems insensible when he scratches himself or when he is pinched; but it is not an unquestionable anæsthesia; when his attention is attracted, it is found that he feels again. What appears to us as characteristic is the evolution of the delirium and the psychological characteristics it presents to-day.

This patient belongs evidently to a family of a very bad character. The father was superstitious and obsessed; the paternal grandfather was often flighty, a thing very hard to interpret to-day; the mother was weak-minded and a drunkard, as well as the maternal grandmother. Daill. has always been timid and impressionable, but has always been regular in his conduct. Having married early, he has a little girl seven years old, who enjoys good health. A year ago he came back home from a little journey, gloomy and preoccupied; he spoke little and would not kiss his wife nor his child. His ill-humour continued, and it seemed, said his wife, that he was becoming dumb, for he made efforts to speak without being

able to succeed and wrote what he wished to say. Soon he spoke a little better, but he had pangs and suffocations, and he went to consult several physicians. One diagnosed angina pectoris, another diabetes.[1] Not much reassured, the patient refused to leave his bed and stopped eating; he remained immovable, scarcely spoke, and ever avoided his wife and child. One morning, without any known cause, he broke out into a satanic laughter which terrified all bystanders. The laughter lasted some hours, and after that the patient was delirious. For six months he has been talking of nothing but demons; he sees them, hears them, feels them within himself, and commits thousands of extravagances.

Such is the exterior aspect of the patient—that is to say, the events he is conscious of and can relate himself if you require it. Now, this delirious patient presents also another state in which he explains his malady in a much clearer way. We may relate here how we obtained subconscious movements and even quite curious automatic writings. The demon spoke in these writings, as the spirits speak in spiritualistic experiments, and even refused to obey us. He yielded when we caught him by his vanity, asking for a proof of his power, and then he determined movements or hallucinations, which the poor, delirious patient experienced without guessing their origin. These subconscious acts could be transformed into a somnambulic state. The patient naturally recovered in this state all his recollections and could explain to us the real psychological phenomena which had induced the different symptoms so badly understood.

Daill., during his journey, had been untrue to his wife and returned home with pangs of remorse and tormented with the notion of a contagious malady. Hence his

[1] It is just to add that a country doctor diagnosed somewhat later "hysterical delirium," and sent him to the Salpêtrière.

dumbness and his dislike for his wife. Then he had dreamt that he was very ill and that he was dying, which explains the period when immovable in his bed. Lastly, he fancied himself carried into hell in the midst of demons. At this moment the subconscious dream had grown and provoked hallucinations in the normal consciousness. The interpretation of the patient did the rest, and determined the delirium. We need not add here that a state of this kind was easy to cure. After a month of treatment the devil was beaten and withdrew altogether.[1]

We do not think that a delirium of this kind should be considered as a common delirium, identical with those of "degenerate heirs." It has very special characteristics, such as have been precisely observed in all hysterical accidents. Delirium has been produced here by the same means which, with other patients, brings about paralysis, contractures, or attacks. Such cases are not rare. You find the same characteristics in mutisms, in anorexias, in lies, hatred, etc. These are the deliriums we consider clearly hysterical.

When the hysterical symptoms of Deni. became still more aggravated, they produced mental confusion—the mania of Par., the systematised delirium of Bans. Is this still hysteria? We are no longer convinced of it. There is in the undoubling (*dédoublement*) of the consciousness proper to hystericals a certain regularity—an equilibrium among the psychological phenomena, a certain order in the disorder. This order itself seems to disappear, the last perceptions vanish, the dream remains quite alone, the fixed ideas have invaded the whole mind. Why not say that hysteria, of a grave character, has been transformed into another mental malady? The

[1] We have just received a letter from Daill. For two years his cure has maintained itself without any drawback.

acute mental confusion, the paranoïa, may be developed secondarily among hystericals; they require a new psychological study, and claim no further attention in the description of the mental state of hystericals.

CONCLUSION

HYSTERIA FROM A PSYCHOLOGICAL POINT OF VIEW

THE definitions of hysteria were formerly very numerous, and every author was obliged to pass in review some fifty formulas presented by his predecessors before he could in his turn express his own thought.[1] But when a more precise study had demonstrated the variety of these phenomena, "more numerous than the forms of Proteus and the colours of the chameleon," it was no longer thought well to bring them together under one and the same formula. M. Lasègue, who, however, was well convinced of the existence of rigorous laws in hysterical manifestations, no longer tries to define this malady. "The definition of hysteria," he says, "has never been given and never will be given. The symptoms are not constant enough, nor sufficiently similar in form nor sufficiently equal in duration and intensity that one type, even descriptive, could comprise them all."[2] He prefers rather "studying separately each of the symptomatic groups, after which introductory work the fragments will be brought together and the whole of the malady will be recomposed."[3]

The advice given by M. Lasègue was followed, and the most competent authors have avoided pronouncing on

[1] See the long preface of Brachet, *Traité de l'hystérie*, 1847, and his chapter on the definitions, p. 202. Very interesting.

[2] Lasègue, "Hystéries périphériques," 1878, *Études médicales*, ii., p. 78.

[3] *Ibid*, "De l'anorexie hystérique," 1873, *Études médicales*, ii., p. 45.

the general definition of the malady. Most of them are content to show a certain number of characteristics which determine the hysterical nature of a phenomenon.'

Perhaps, when we declare the definition of hysteria impossible, we make too ambitious an idea of it. We are evidently incapable, in this case as in all others, of making known the true nature of it, the essence of a thing, or the last explanation of any phenomenon. No definition, except in the purely rational sciences like mathematics, has ever given either essence or explanation. Our definitions are nothing but general ideas, résumés which should comprise only the greatest number of possible facts. A definition would be perfect if it embraced in one and the same formula absolutely all the facts that can be observed of an object. It cannot be realised, because we do not know all these facts. A definition would be excellent if it embraced only all the known facts, but this is again a hardly realisable ideal. A definition is sufficient when it expresses in one phrase the majority of known facts. Of course such a formula, like all scientific theory, is provisional, since there is a constant increase of known facts, which renders it soon too narrow. We do not annul such a definition by simply showing that such or such detail is not comprised in it; to do that, it is necessary to oppose to it a simpler and more general definition, embracing not only the facts comprised in the first, but others also. If we are content with this modest conception of definition, has anybody the right to say that a sufficient definition of hysteria is nowadays impossible? Is there no common characteristic that brings nearer to each other the majority of the facts that have been gathered from all sides? If that were so, hysteria would not exist and would not deserve to be studied as a distinct malady.

[1] Babinski, "De la migraine ophtalmique hystérique," *Archives de neurologie*, 1891, extrait, p. 81; Pitres, *op. cit.*, i., p. 4.

§ 1—HYSTERIA, MALADY BY REPRESENTATION

A definition, we know, can sum up facts only by grouping them around a phenomenon,—" a dominant phenomenon," that is to say,—putting in the first rank a characteristic declared by hypothesis the most important, and showing as clearly as possible that all the other facts depend on this characteristic. In the old definitions, the characteristic oftenest chosen as the most essential was a physical characteristic, a real or supposed modification of the elementary physiological phenomena. For a very long time the movements of the uterus across the body—its alterations, its pains—have been the centre around which gravitated all the other symptoms. These definitions comprised but a very limited number of phenomena. Later, another phenomenon, which was also considered as a purely physical fact,—the attack, namely,—became predominant, and hysteria became an essentially convulsive malady. " *Hysteria*," said M. Brachet, " *is a neurosis of the cerebral nervous system, which manifests itself more or less brusquely by crises of general chronic convulsions and by the sensation of a globe ascending in the course of the œsophagus, at the upper extremity of which it becomes fixed, causing there a menace of suffocation.*" [1] These definitions were a little more comprehensive than the foregoing ones; the phenomena connected with the attack were certainly more numerous than those dependent on uterine modifications. But they presented a great lacuna; they left aside, almost completely, the interparoxysmal accidents which are so numerous. Since a large number of authors could not succeed in grouping symptoms around a physical phenomenon, they have somewhat changed their point of view and tried if, among the psychological cerebral phenomena which had long since been observed in this

[1] Brachet, *Traité de l'hystérie*, 1847, p. 204.

malady, there might not be found a more important symptom, capable of co-ordinating a great number of facts. The definitions of hysteria were transformed and are now psychological.

M. Briquet's book (1859) is, from this point of view, of great importance; it fills, so to say, an intermediary place between the conceptions purely physical and the moral interpretations of hysteria. "*Hysteria*," he says, "*is an encephalic neurosis, whose apparent phenomena consist principally in the perturbation of the vital actions which serve to manifest the affective sensations and passions.*" [1] Hysteria becomes an emotional malady, and undoubtedly one can easily connect a very great number of symptoms with emotional phenomena. Unfortunately, emotion is imperfectly analysed by M. Briquet, and the explanation of the principal symptoms is very vague. One point above all, among many others, was embarrassing. Emotion is apparently an accidental and momentary phenomenon; how, then, can we connect with it permanent symptoms—symptoms which last for months and years? And can we suppose permanency in emotion when the patient appears quite calm and indifferent? Nevertheless, M. Briquet's study may be considered as the starting-point of psychological research concerning hysteria.

This study began in an exact and precise manner only with the labours of Professor Charcot at the Salpêtrière, on the traumatic accidents of the hystericals: the paralyses, the contractures, mutisms, or anorexias. Everywhere, as we have seen, he showed the importance of the fixed idea which produced and kept up the accident, the reproduction of identical facts by suggestion, the treatment by isolation, and the moral influences which modified not the physical state, but the mental pathological state of the hysterical. It remained to generalise somewhat more this conception and apply it to the whole of hysteria.

[1] Briquet, *Traité clinique et thérapeutique de l'hystérie*, 1859, p. 3.

This was, we believe, M. Mœbius's part. This author renders most courteous homage to M. Charcot's works and has completed them in a most interesting manner. "There is," he says, "an opinion tending more and more to become established, namely, that hysteria is a psychosis, and that the essential modification which characterises it is an unhealthy state of the mind."[1] It is, however, not identical with all insanity; the movements of the lunatic are but indirectly connected with his delirium; it is the patient himself who moves about and wants to move about to obey an imaginary order. In hysteria, the relation is more immediate; the thought is transformed into motion without the mediation of the subject's will. This is a characteristic fact which has helped M. Mœbius to formulate a definition of this malady: "*We may consider*," he says, "*as hysterical all the sickly modifications of the body which are caused by representations.*"[2] M. Strümpell's lecture expresses similar ideas: "*What is called nervousness, is, from a scientific point of view, above all a spiritual and not a corporeal disposition. . . . Certain representations too strong, certain associations of ideas too easy, become the starting-point of a great series of accidents apparently corporeal.*"[3] M. Strümpell agrees with the preceding authors in explaining these neuropathic accidents by representations (durch Vorstellungen). For the purely physical definitions of hysteria is then substituted a new definition which endeavours to group symptoms around a moral phenomenon. "*Hysteria is an ensemble of maladies through representation.*"

[1] Mœbius, "Ueber den Begriff der Hysterie," aus dem *Centralblatt für Nervenheilkunde*, von D. Erlenmayer, xi., 1888, No. 3.

[2] Mœbius, *op. cit.*, p. 2.

[3] A. Strümpell, *Ueber die Entstehung und die Heilung von Krankheiten durch Vorstellungen*. Rede beim Antritt des Prorectorats der Kgl. Universität, Erlangen, Nov., 1892, p. 8.

§ 2—THE UNDOUBLING (*DÉDOUBLEMENT*) OF THE PERSONALITY

A large number of hysterical accidents appear to depend on certain fixed ideas, on certain suggestions; but can we, as M. Mœbius has tried, apply this explanation to all accidents and transform it into a definition of hysteria? This has seemed very contestable to several authors, and was justly criticised by M. Oppenheim; then by M. Jolly.[1] Let us try to give some sort of precision to these vague criticisms by following the method which we have proposed for examining the definitions.

1. A great number of hysterical accidents, clearly localised like the preceding ones,—hyperæsthesias, tics, paralyses, spasms,—do not seem connected with any idea, with any imaginary object in the mind of the subject. The patient, whichever way you question him, and notwithstanding his good nature, affirms that he does not think of moving his arm, of closing his hand, of making a face; better still, he has no idea of this spasm; he does not even feel it; he discovers with surprise his own accidents without knowing how they are produced. There are, in fact, two categories of hysterical accidents, which in particular can be easily distinguished by examining tics or spasms. Some take place *when the subject thinks of it;* they disappear when the subject's attention is diverted or when he falls asleep. Those may easily be connected with an idea. But very often it happens that the morbid movement is produced even *when the subject does not think of it;* the spasm persists despite the mind's diversion, sometimes despite sleep. Here, then, we have no longer, at least not in appearance, accidents which depend on a mental representation. At the outset, perhaps, the subject was conscious of an emotion, of an idea more or less vague; but it is evident that these phenomena

[1] Oppenheim, *op. cit.*, p. 3; Jolly, *op. cit.*, p. 12.

of consciousness have very quickly disappeared and that they actually no longer exist.

2. The hysterical does not only present permanent accidents of this kind; she presents a much more frequent and much better-known phenomenon—namely, the attack. Now, this attack is not a simple act like a contraction of the hand; it is a complex ensemble of convulsions, of cries, of words. The subject has not in his mind the representation of all this series of phenomena; he is even ignorant of them, since, in the majority of cases, he awakes from the attack without well knowing what has happened. These attacks, reproduced with monotonous regularity, seem to depend on some physical phenomena, for they are independent of the subject's thought, and it is sometimes enough to provoke them, not, indeed, to awaken the ideas of the subject, but to press a certain point of the body,—the ovary or epigastrium,—for the discharge to take place.

3. Let us consider now accidents more strictly moral,—deliriums, somnambulisms, which unquestionably belong to hysteria. We are not, however, with any more certainty confronting a fixed idea, clear and simple. The subject does not know what is going on during his somnambulic sleep or his delirium, and he does not think of it. When the accident occurs, it is composed of a long succession of sensations and a variety of thoughts which the patients had nowise foreseen.

In a word, even leaving aside the stigmata, and considering only the accidents, it is impossible to bring them all back to corporeal modifications produced by conscious representations.

Let us, then, endeavour to change our point of view and take another phenomenon as centre of the definition. We have here again, then, the studies of M. Charcot and of his pupils, who have shown how great a part *somnambulism* plays in hysteria. This phenomenon presents

itself under many circumstances, at first spontaneously with these patients; and besides it may be induced artificially, —if not with all, at least with most hystericals. To forget all that has happened during the somnambulic sleep when the subject returns to his normal state seemed to us the only constant and essential character of somnambulism, and this amnesia, followed by a periodic return of recollection, established a sort of scission between the two states. A truly somnambulic individual lives in two different ways. He has "two psychological existences successively alternating."[1] In one he has sensations, remembrances, movements, which he has not in the other, and consequently he presents, in a manner more or less clear, according to cases, two characters, and in some sort two personalities. The simplest somnambulism should be considered as identical with these great phenomena of double existence, which are sometimes so manifest. It is always the result, the manifestation, of an undoubling (*dédoublement*) of the personality.

If somnambulism is so understood, it is easy to observe that a great number of hysterical accidents may be related to it. Not only the long periods of the double existence, but very short states of duration, during which the patient appears to walk, act automatically, runs off, experiences reveries, ecstasies, etc.

We have tried to show, following M. Charcot's example, that the closest ties may be established between the somnambulism and the attack. These two phenomena are induced in the same manner, bring about the same amnesia, followed by alternating memory, and give birth to the same undoubling (*dédoublement*) of the personality.[2] Automatic regularity characterises equally all these states, for the second existence is often a rudimentary psychological existence, in which the sensations and

[1] *Autom. psychol.*, p. 448.

[2] *Ibid.*, p. 456; Breuer et Freud, *op. cit.*, 1893, ii.

the ideas, not very numerous, do not control and do not modify each other. The fixed ideas, which we have seen play so great a rôle during the waking hours of the hysticals, are here far more powerful and develop with more regularity. Most attacks can be interpreted as the reproduction, more or less complete, of an emotion, an action, an old idea in a second existence, which is comparable to a more or less rudimentary somnambulism.

These studies of attacks and somnambulisms seemed to bring closer together and reunite an important category of hysterical symptoms,—the periodical accidents, for example,—but they seemed to leave aside the permanent accidents, those disturbances of movement so well summed up, on the other hand, by M. Charcot's and M. Mœbius's theories. Is the separation of these two groups of facts also absolute? We did not think so; we have sought their reunion in studying the manifestations of the second personality in the interval of somnambulisms and attacks.

The study of the suggestions of post-hypnotic effect, executed in an intelligent manner, although apparently without the knowledge of the subject and without his consciousness, and the analysis of acts called unconscious and of the automatic writing of mediums have shown us again the same undoubling (*dédoublement*) of consciousness. But now the second group of psychological phenomena, instead of alternating with the first, developed simultaneously below and outside of the normal thought of the subject. In a word, all the psychological phenomena that are produced in the brain are not brought together in one and the same personal perception; a portion remains independent under the form of sensations or elementary images, or else is grouped more or less completely and tends to form a new system, a personality independent of the first. These two personalities are not content merely to alternate, to succeed each other; they

can coexist in a way more or less complete. A great number of hysterical accidents are connected with this type of hemisomnambulism, the same as the attacks are connected with the type of somnambulism.[1] We have been obliged to admit that in many accidents the fixed idea, which was to provoke them and keep them up according to M. Charcot's theory, could not be expressed by the patient, for he was wholly ignorant of it. We understand now that these ideas may exist in him, although he may not be conscious of it. And this is not a simple and possible supposition; it is a fact which can be clinically demonstrated.

How often have we not shown that the subject, by automatic writing, could, while awake, express those fixed ideas? Oftener still have we established that the subject, while in such or such hypnotic state, recovered completely the memory of those subconscious fixed ideas.

Such fixed ideas, existing outside the personal perception, play in hysteria a prime rôle. They can determine the most varied of the disturbances of movement; they give rise to hyperæsthesias; they bring about hallucinations, for the separation of those two states of consciousness is far from being absolute, and a phenomenon that has been provoked in one by a whole series of associations of ideas may appear suddenly in the other; they can disturb and cloud the mind, induce the strangest forgetfulness, and even a sort of delirium. The power of such ideas depends on their isolation; they grow; "they install themselves in the mind in the manner of parasites,"[2] and cannot be stopped in their development by the efforts of the subject because they are not known, because they exist aside, in a second thought, separated from the first.

Two English psychologists, MM. Gurney and Fr. W.

[1] "Actes inconscients, . . ." *Revue philosophique*, 1886, ii., p. 577.
[2] Charcot, *Mal. du syst. nerv.*, iii., p. 455.

Myers, who have contributed much to the progress of these studies, both by their own works and by the impulse they have given to the *Society for Psychical Research*, have often expressed similar ideas regarding the mechanism of hysterical accidents. " The essential character of hysteria," says M. Myers, " is an unreasonable autosuggestion in regions of the mind which are below the power of the normal consciousness, *beyond the powers of the waking will* . . . hysteria is a malady of the hypnotic layer, *disease of the hypnotic stratum.*" [1]

These remarks had formerly induced us to consider these dissociations of the psychological phenomena as an essential characteristic of hysteria: " This fact," we said, " must play in this disease a rôle as great as that of association in normal psychology." [2] A little later, we were explaining divers accidents in hysteria, and in particular contractures, " by a veritable activity of the second group of images, separated from the normal consciousness." [3] " The essential character of this disease of disintegration was the formation, in the mind, of two groups of phenomena, one constituting the ordinary personality, the other being, besides, susceptible of subdivision, forming an abnormal personality different from the first and altogether unknown to it." [4]

At the same time, M. Jules Janet, in order to sum up the researches we had made, added a new and most interesting observation. He sought to express a new conception of hysteria.[5] One may perhaps criticise this work for being somewhat schematic, but it has the great merit

[1] Fr. W. H. Myers, "The Subliminal Consciousness," *Proceedings of the Society for Psychical Research*, 1892, p. 309, and 1893, p. 5.

[2] " L'anesthésie systématisée et la dissociation des phenoménes psychologiques," *Revue philosophique*, 1887, p. 472.

[3] *Autom. psychol.*, 1889, p. 362.

[4] *Ibid.*, 1889, p. 367.

[5] Jules Janet, " Hystérie et hypnotisme d'après la théorie de la double personalité," *Revue scientifique*, 1888, i., p. 616.

of summing up very clearly a rather delicate psychological conception which at that time was imperfectly understood.

The incomplete state of the first personality,—he says,—constitutes the blemishes of hysteria; it allows the irregular action of the second personality,—that is to say, hysterical accidents. The second personality, always concealed behind the first, the stronger as the latter is weaker, takes advantage of the least chance to overcome it and show itself in full light.[1]

A great number of psychological studies were made immediately upon this undoubling (*dédoublement*), but it is not our intention to treat here any except the medical conceptions of hysteria. M. Laurent, in a work which first appeared in the *Archives cliniques de Bordeaux*,[2] and reproduced later with developments in his thesis for the doctorate,[3] shows the great part which the secondary states and the subconscious phenomena play in hysteria, and considers them characteristic of this disease. But the most important work that has come to confirm our earlier studies is, without contradiction, the article of MM. Breuer and Freud, which recently appeared in the *Neurologisches Centralblatt*.[4]

We are very glad that these authors, in their independent researches, have been able to verify ours with so much precision, and we thank them for their kindly reference to us. They show by numerous examples that the various symptoms of hysteria are not spontaneous

[1] Jules Janet, *op. cit.*, p. 622.

[2] L. Laurent, "De l'état mental des hystériques d'après les théories psychologiques actuelles," *Archives cliniques de Bordeaux*, sept. 1892.

[3] L. Laurent, *Des états seconds, variations pathologiques du champ de la conscience*, 1892.

[4] Josef Breuer et Sigm. Freud in Wien, "Ueber den psychischen Mechanismus hysterischer Phaenomene," *Neurologisches Centralblatt*, 1893, Nos. 1 and 2.

manifestations, idiopathic of the disease, but are in close connection with the provocative trauma. The most common accidents of hysteria, even hyperæsthesias, pains, commonplace attacks, should be interpreted in the same way as the accidents of traumatic hysteria—namely, by the persistency of an idea or a dream. The relation between the provocative idea and the accident may be more or less direct, but it exists always. We should, however, establish the fact that the patient often, in his normal state, knows nothing of this provocative idea, which is not clearly found again except during the periods, natural or provoked, of the second state, and it is precisely to their isolation that these ideas owe their power. The patient is cured, say these authors, when he succeeds in finding again the clear consciousness of his fixed idea.

"*This division of the consciousness, which has been clearly established in some celebrated cases of double existence, exists in a rudimentary state in every hysterical; the disposition to this dissociation and at the same time to the formation of abnormal states of consciousness, which we propose to bring together under the name of hypnoid states, constitutes the fundamental phenomenon of this neurosis.*"[1] This definition goes to confirm those which we have already given, which seek to group all the symptoms of the disease around a principal phenomenon, the undoubling of the personality.

§ 3—RETRACTION OF THE FIELD OF CONSCIOUSNESS

The preceding definitions are certainly quite general; they apply to the great majority of hysterical accidents, but, on the other hand, it is evident that they pass by almost completely other characters equally numerous and very important—namely, the stigmata.

[1] Josef Breuer and Sigm. Freud, p, 7. The authors add, p. 4, but not in so many words, that these ideas come also nearer those of Benedikt. We regret not to be acquainted with that work.

Certain authors have tried to apply to the stigmata the same explanation as to the accidents, and equally to connect them with the fixed ideas. This explanation would be simple, and conforms to the principles we have adopted, but it has been seen that there could not be established in anæsthesias either evolution or the characteristics of fixed ideas. We may consider them as the proof of a lessening of the nervous functions, an exhaustion of the organs. This is not a theory; it is the expression, as just as it is common, of the fact itself; it remains now to interpret the nature of this exhaustion.

We can hardly discuss here an exact theory, for most authors who speak of this exhaustion have expressed themselves in the most vague and confused manner. The question presents itself to us as follows: Is this exhaustion,—the primitive causes of which we have not here to look for, be they heredity, degeneracy, intoxication, or accidental lesions,—is it localised in such or such sensory organ, or does it bear, in a general way, upon the superior parts of the brain ? Can we say that tactile anæsthesia, the contraction of the visual field, are precisely related to a stoppage of the function of the nervous centres which serve this tactile or visual sensation, or, rather, are those anæsthesias only a special manifestation of an enfeeblement bearing on all the functions of the cerebral cortex, and do they consequently connect themselves with a general disturbance of the psychological functions ?

We do not believe that the stigmata are due to local lesions of the sensory apparatus, of the muscles, nerves, or centres. (1) The stigmata are too mobile; they disappear too easily as soon as you modify somewhat the thought of the subject; the suggestion, the association of the ideas, especially the attention, suppress as if by enchantment these insensibilities and these muscular impotencies; (2) the stigmata are contradictory—that is to say,

the function of the organs is real and continues to the very moment at which it seems to be suppressed. We have shown in numerous studies that the tactile sensation, the visual sensation, even at the periphery of the visual field, continued to be exercised, despite anæsthesia; that the remembrances were reproduced despite apparent amnesia, that the movements were possible, and that they had even preserved their strength despite the weakness, the amyosthenia indicated by the dynamometer.[1] These facts can be demonstrated by a great number of exact experiments, but they may be established by the simplest clinical observation. Hystericals walk, run without falling, without knocking against any obstacles, as real anæsthetics should do,—patients, namely, who have their visual field truly reduced to a point. You see them work, lift burdens, exercise for a long time when they are not conscious of being observed, while they exhibit an astonishing muscular weakness, an extremely rapid fatigue, as soon as you subject them to an examination. We were very glad to hear M. Jolly make independently the same remark. He speaks of children having a complete hysterical amaurosis, and he adds: "These children, who seem to see no light, avoid obstacles put, without their knowledge, in their way, and yet they are not led by the touch, . . . they do not look like the really blind . . . there must be here some kind of perception"; and further: "I have many reasons for believing that this deafness cannot be real. . . . I do not doubt that the child heard the conversation."[2] M. Oppenheim also says: "The hysterical has lost the will to put in motion groups of determined muscles, . . . it is a very different thing to put these muscles in motion by an effort of the will or by the mediation of an affective state."[3] This quick reappearance, and

[1] Cf. *Stigmates mentaux des hystériques*. ch. i.

[2] F. Jolly, *op. cit.*, p. 4.

[3] H. Oppenheim, *op. cit.*, p. 6.

this preservation of phenomena prevent our believing in a localised exhaustion.

The general exhaustion of the cerebral functions has been pointed out by many authors. "Hystericals," said M. Féré, "are in a permanent state of psychical fatigue, which is shown by a weakening of sensibility, of motion, of the will."[1] "The fundamental factor of hysteria," says M. Oppenheim, "is irritable feebleness, an abnormal excitability accompanied with exhaustion. These characteristics are especially established in the sphere of the affective phenomena."[2] M. Jolly, taking up again M. Oppenheim's conception, speaks also of an extreme nervous feebleness, which allows the exaggeration of the affective phenomena, but he adds that this formula lacks precision and does not sum up particular facts.[3] We think, as does this author, that it is necessary to define this cerebral weakness with more precision and explain what is meant by it. As the essential functions of the brain are psychological functions, we must show, by the analysis of the moral phenomena, wherein this psychological insufficiency consists.

We purposed formerly to study a psychological phenomenon, which was already pointed out more or less vaguely among the disturbances of the character of the hystericals, and which seemed to us the principal expression of this insufficiency. The question is a feebleness of attention or rather a state of perpetual absent-mindedness easily established among most of these patients. The attention is painfully slow in fixing itself, is accompanied with accidents of all sorts, is quickly exhausted, and gives but a minimum of results; it forms but vague, doubtful, surprising, and unintelligible ideas.[4] If we

[1] Féré, *Sensation et mouvement*, 1887, p. 21.
[2] Oppenheim, *op. cit.*, 1889, p. 3.
[3] Jolly, *op. cit.*, p. 12.
[4] *Les stigmates mentaux des hystériques*, p. 130, above.

consider attention under its motor aspect, when it is applied to actions, we find again the same characteristics. Voluntary acts are slow, painful, of short duration, interspersed with innumerable stoppages. Often this so feeble attention seems even to disappear entirely; all attention, all voluntary acts become then impossible; the subject is no longer able to understand what he reads, nor even what he hears; he can no longer make the smallest voluntary motion. Abulia, aprosexia, hesitation, doubt,—we think we should insist on this,—are the psychological and essential characteristics of the hystericals. These characteristics, it is evident, are found more or less similar among other patients, but it is not a sufficient reason for neglecting them with the hysterical.[1]

These weaknesses of attention are so great that they not only interfere with the intellectual works, but even modify the normal life, the ordinary thinking, which requires continually a certain effort of attention. The patient perceives imperfectly the things happening about him; he takes no account of all the situations of life, and he perceives only a very small portion of the facts; he seems always to forget the major part of the impressions which ought to strike him.[2] If we try to verify this mental state in a more precise way, we establish that a hysterical woman cannot experience several sensations at the same time. As soon as she experiences a feeling of any kind she becomes indifferent to all the other excitations made on parts of the body and on organs ordinarily sensitive. She presents the same absence of mind for remembrances, and while she thinks of one idea she forgets all the contrary notions which she knew quite well a moment before. Lastly, we establish the same character in her acts and movements; voluntarily she makes but one movement at a time and loses the power of doing it the

[1] *Les stigmates mentaux des hystériques*, p. 118, above.

[2] *Autom. psych.*, p. 188.

moment her attention is diverted by a sensation or another movement. This last point has been particularly studied in M. Pick's interesting work.[1] Similar absences of mind exist rarely with the normal man, and are produced only by an excessive concentration of the mind upon a complicated problem; with the hysterical, they are produced in a much simpler way. "It is an exaggerated state of *absent-mindedness*, which is not momentary and is not the result of voluntary attention turned in only one direction; it is a state of natural and perpetual absent-mindedness which prevents those persons from appreciating any other sensation except the one which for the time occupies their mind."[2]

We endeavoured formerly not to explain, but to summarise, all these many facts into a simple formula. Psychological life not only consists of a succession of phenomena coming one after the other, and forming a long series in one direction, but each of these successive states is in reality a complex state; it contains a multitude of more elementary facts and owes its apparent unity to synthesis alone, to the systematisation of all these elements. We have proposed to call "*field of consciousness*, or maximum extension of consciousness," the largest number of simple, or relatively simple, phenomena, which might be gathered at every moment, which might be simultaneously connected with our personality in one and the same personal perception."[3] This field of consciousness, thus understood, is very variable. A chief of orchestra, hearing simultaneously all the instruments, and following by reading or his memory the partition of the opera, unites in each of his

[1] A. Pick, "Ueber die sogenannte 'Conscience musculaire' (Duchenne)," *Zeitschrift für Psych. und Physiol. der Sinnesorgane*, iv., 1892; Cf. *Stigmates mentaux de l'hystérie*, p. 161, above.

[2] *Autom. psych.*, p. 189.

[3] *Ibid.*, p. 194.

states of consciousness an immense number of facts. The individual who, when asleep, dreams, and the patient during a crisis of ecstasy, have, on the contrary, in their conscious thought only a very limited number of facts. It is easy to see, in studying the absent-mindedness of hystericals, that their field of consciousness is very small; it is filled entirely with one relatively simple sensation, one remembrance, a small group of motor images, and cannot contain others at the same time. This limitation of the field of consciousness is but a manifestation of the general cerebral exhaustion which has been often admitted. This exhaustion, we think, is described with more precision when we say: *It is a special moral weakness, consisting in the lack of power on the part of the feeble subject to gather, to condense, his psychological phenomena, and assimilate them to his personality.*[1]

This remark allows the grouping of a great number of facts, of traits of character which have often been pointed out in hystericals. Their transitory enthusiasms, their exaggerated and quickly appeased despairs, their irrational convictions, their impulses, their caprices,—in a word, this excessive and unstable disposition seems to us to depend upon this fundamental fact that they always give themselves entirely up to the present idea, without any of that reserve, that mental restriction, which give to the thought its moderation, its equilibrium, and its transitions.

It is again,—said M. Laurent,[2]—to the retraction of the field of consciousness that we must ascribe, in the hysterical, her fears, her astonishment, emotiveness, the manifestations of the intensity of her impressions. A certain impression effacing suddenly pre-existent ideas, the hysterical is found in the situation of a man who learns something all of a sudden or

[1] *Autom. psych.*, p. 454.
[2] L. Laurent, *États seconds*, 1892, p. 127.

who sees something he does not expect to see. This impression expels the other ideas and, overruling intelligence, causes, according to its nature, astonishment, fear, joy; being by nothing counterbalanced, moreover, no reasoning supervening, the instinctive expression of the thought manifests itself.

The same remarks may apply to the sudden impulses of these patients and their quick changes of mind. It is simply a more precise psychological expression of what has been vaguely described under the name of irritable weakness.

We believe that we can go still farther, and that the stigmata, and anæsthesia itself, may be considered as a dependency of this psychological character.

Anæsthesia acts like absent-mindedness; it is variable, mobile; it often disappears just at the moment when one is about to provoke an effort of attention on the part of the patient. It is neither deep nor complete, for it allows the existence of elementary sensations in the form of subconscious phenomena easy to establish in many cases. We can produce, through absence of mind itself, insensibilities which have all the characteristics of hysterical anæsthesias. When the repartition of anæsthesia becomes modified, which is quite frequent, we establish alternations, equivalences in the sensations which have disappeared. "Sensibility," said M. Cabanis formerly, "seems to act in the manner of a fluid, the total quantity of which is determined, and which, every time it throws itself in greater abundance into one of its canals, diminishes proportionately in the others."[1] If you force the subject, by attracting his attention, to recover the sensibility of the left side, he loses it on the right side. If you obtain the total tactile sensibility, the reduction of the visual field increases so much that the

[1] Cabanis, Histoire des sensations dans l'étude sur le rapport du physique et du moral, *Œuvres complètes*, 1824, iii., p. 153.

subject becomes momentarily blind, a thing we have observed a number of times without having foreseen it. If you wish to enlarge the visual field, the tactile anæsthesia will increase. These modifications happen often in a spontaneous manner, and certain subjects seem to have a choice among several forms of equivalent anæsthesias. These alternations exist not only for anæsthesias, but for many other phenomena, and this is the reason why hystericals are not cured when one of their symptoms has been more or less completely suppressed. The feebleness of their thinking continues, and they lose on one side what they seem to have regained on another. The localisation of anæsthesia may depend on a suggestion or a fixed idea, but anæsthesia in itself and the stigmata in general are manifestations of the insufficiency of the personal perception, of the retraction of the field of consciousness.

M. J. Héricourt, when he made a résumé of our study on hysterical anæsthesia, gave a very happy expression to our thought.

It is from a sort of laziness that the principal personage suppresses a whole series of sensations, those that are the least indispensable to him, in order to limit the field of an activity whose cost he might be at some trouble to bear. . . . This rejection of a whole group of troublesome psychical elements would constitute a kind of spontaneous psychological autonomy, of which there exist besides some cases not to be doubted.

Thus, it is known that the persons who have one cross-eye suppress completely the vision of the eye affected by strabismus and see in reality out of one eye only, although both their eyes are equally sensitive to retinal impressions.[1] We therefore think that the stigmata may be summarised by the following formula:

[1] J. Héricourt, "L'activité inconsciente de l'esprit," *Revue scientifique*, 1889, ii., p. 262.

Things take place as if the elementary psychological phenomena were as real and as numerous as with normal individuals, but they cannot, on account of the retraction of the field of consciousness, on account of this weakness of the faculty of synthesis, unite themselves into one single perception, into one single personal consciousness.[1]

This new conception, to which we have been brought through the study of the stigmata, is far from being in opposition to the conclusions of our foregoing studies concerning accidents. The undoubling (dédoublement) of the personality is rather the immediate consequence of this weakness of psychological synthesis. The latter allows psychological phenomena to subsist, but does not unite them to the idea of the personality. We may represent to ourselves somnambulic facts, subconscious acts, as secondary groupings, as accessory systematisations of those neglected psychological phenomena.

Things take place as if the system of the psychological phenomena which forms the personal perception with all men, were with these individuals disintegrated and giving birth to two or more simultaneous or successive groups, mostly incomplete, and robbing each other of sensations, images, and consequently movements which should be normally reunited in one and the same consciousness and the same power.[2]

Suggestibility itself and the maladies by representation connect themselves with this general conception. The exaggerated development of certain ideas depends on their isolation, and this isolation is a consequence of the retraction of the field of consciousness. The exaltation of the automatic phenomena springs generally from a diminution in the power of the voluntary activity which at every instant of our life reunites the present phenomena. It is the ensemble of these conceptions that

[1] *Autom. psych.*, p. 364. [2] *Ibid.*, p. 364.

we have designated by the name of *mental disintegration*, and it seems yet, according to the preceding analyses, that this idea might furnish the means of summarising a great number of hysterical phenomena.

Several authors have accepted this résumé of the facts and have completed it with new examples. M. Pick considers *the diminution of the power of attention, the retraction of personal perception, to which he adds the retraction of motor impulsion, as the characteristic of hysteria.*[1] M. Laurent expresses himself in about the same terms:

> We say hysterical, for to-day it is the only scientific word left to designate mental retraction, the *minus habens conscientiæ*, if we may thus express the mental state of that very intelligent individual, perhaps, whose every mental faculty yet is marked by a stigma more fixed certainly than any of those we are accustomed to seek in hysteria.[2]

This retraction of the field of consciousness may certainly be found among a great number of patients: among many insane (of course, not among all), among the neurasthenics, the stupid ones, the imbeciles, and idiots. Shall we conclude by this that we have wholly confounded the hysterical with the idiot? We might as well say that the naturalist confounds the dog with the lizard because he calls them both vertebrates. The retraction of the field of consciousness is a great pathological characteristic which is manifested in a thousand different ways. All the descriptions and studies contained in this work are intended to demonstrate how this characteristic is manifested in the hysterical. We recall here only that the elementary psychological phenomena subsist almost without modifications; that a portion of them separates *completely* from the personality, which gives rise to anæsthesias, amnesias, very distinct paralyses; that these dis-

[1] Pick, *op. cit.*, 1892, pp. 190, 208.

[2] Laurent, *Les états seconds*, 1893, p. 154.

sociated phenomena unite among themselves to form distinct psychological states of the normal consciousness. We do not believe that the weakness of the psychological synthesis is very often manifested under this form outside of hysteria.

§ 4—HYSTERIA, MENTAL MALADY

"We say boldly no," wrote M. Brachet, in 1847, "no, the brain is not essentially hurt in hysteria."[1]

Since that time opinions have singularly changed; it is rare nowadays to meet with physicians who look upon hysteria as a disease of the genital organs, and who deprive women of their ovaries to cure them of their fixed ideas. "It is evident," says M. Jolly, "that, in the course of time, the theory of hysteria has been brought nearer and nearer a psychological interpretation."[2] "Paralyses by segment of member," said M. G. Guinon, "are cerebral phenomena; hemianæsthesia also; the mental state, the important syndrome with hystericals, is directly dependent on the brain function. We must then admit that hysteria is a specially cerebral neurosis."[3]

"Hysteria is only a mode of brain function," says M. Sollier, . . . "there is no such thing as an hysterical malady . . . there is a cerebral mechanism that is hysterical; the brain itself is not affected."[4] In the recent *Dictionary of Mental Medicine*, by M. Hack Tuke, the two articles devoted to hysteria come to the same conclusion:

Hysteria, according to M. Donkin, is a disorder or a defective development of the highest functional centres of the

[1] Brachet, *Hystérie*, p. 294.
[2] Jolly, *op. cit.*, p. 11.
[3] Georges Guinon, *Les agents provocateurs de l'hystérie*, 1889, p. 354.
[4] Sollier, *Amnésies*, 1892, p. 323.

cerebral cortex. . . . There is even some risk in mistaking hysteria for a species of insanity, as well as in endeavouring to group the phenomena around a physical symptom of this disease.[1]

In the same work, MM. Charcot and Marie connect likewise hysteria with a disturbance in the working of the highest cerebral regions. Hysteria, according to them, is less a disease, in the ordinary sense of the word, "than a particular mode of feeling and reacting."[2] All the studies we have made thus far lead us to bring hysteria within the group of mental maladies. We must, however, examine the difficulties such an assimilation presents, not to solve them completely, but that we may account for the practical value of our provisional definition of hysteria.

In order to criticise this definition, which tends to make of hysteria a mental malady, we ask to be permitted to follow an old method which goes back to scholasticism, but which is quite to the point. *Conveniat toti et conveniat soli definitio*, they used to say concerning a definition. We shall first inquire if the foregoing conceptions are broad enough to apply to all hystericals, to contain, namely, all the symptoms which these patients might present, and next whether they are exact enough to characterise hysteria alone and distinguish it from the other diseases of the mind.

Let us first consider the first point: The conception of hysteria, considered as a mental malady—does it summarise all the symptoms of this malady? No doubt a great number of phenomena, formerly described as physical, are to-day regarded as psychological: paralyses, contractures, choreas, hyperæsthesias, anæsthesias, are

[1] Donkin, "Hysteria," *Dictionary of Psychological Medicine*, i., p. 619.

[2] Charcot et Marie, "Hystero-epilepsy," *Dictionary of Psychological Medicine*, 1892, i., p. 628.

moral symptoms; but there exist other hysterical accidents the psychological interpretation of which is far less advanced and much less probable. We think we can classify them in three principal categories: (1) The visceral accidents of hysteria; (2) the vaso-motor and secretory disturbances; and (3) the trophic troubles.

The visceral accidents are very numerous among hysticals, and even among some patients they are altogether predominant. Let us but recall the cardiac palpitations and even certain alterations in the heart-beats, hysterical fever, already pointed out by M. Briquet,[1] which, to-day, justly attracts attention, the nervous coughs, sobs, hiccoughs, and all sorts of modifications of the respiratory rhythm. It often seemed to us as if these patients presented in an exaggerated manner a particular type of breathing, the upper costal type (costo-superieur); the inferior ribs and the diaphragm appear sometimes entirely reduced to immobility; the alterations in the movements of the diaphragm are, besides, extremely frequent. However, we know that the most numerous accidents bear on the digestive system; it is easy to establish anorexias of various kinds, troubles of deglutition, spasms of œsophagus at various heights, vomitings; then intestinal phenomena—diarrhœas, as well as constipations, distensions of the abdomen, paralyses, or sphincter-spasms, troubles of the same nature in the emission and even in the secretion of the urine, etc. Hysterical ischuria is one of the most important of these phenomena; "the main fact here is a considerable diminution in the amount of excrementitial matter, despite the presence of urea in the vomitings."[2]

The alterations of the vaso-motor functions are already manifest in the troubles so common in the menstrual phenomena, in those supplementary hemorrhages through

[1] Briquet, *op. cit.*, p. 493.
[2] Charcot, *Mal. du syst. nerv.*, i., pp. 278, 296.

the nose, the stomach, the lungs even. But they may also be established on the cutaneous surface and in the peripheral organs. Many patients have on the skin red spots slighty protuberant, which appear before or after the attacks and stay a greater or shorter time. Many present a notable swelling of the vascular glands. The vascular goitre is frequent among hystericals, and with some it develops suddenly in consequence of an attack or an emotion. Lastly, the vaso-motor reflexes are not always normal: the question here is not, of course, of physiological experiments, which are, as we know, extremely contestable, but simply clinical verifications. Pricks do not bleed, pinchings, on the other hand, even when slightly done, provoke exaggerated ecchymoses. The application of an object slightly heated brings on burns, etc., and these phenomena are not identical, if you operate on the anæsthetic or on the sensitive side. In short, you have but to point out the curious phenomena of the dermographic skin. We do not mean to analyse here all these observations; we wish simply to recall them.

We know the surprising observation of the milky secretion reported by M. Briquet.[1] Perhaps similar cases might be found of "irritable breast," pointed out by several authors. But, without seeking for such rare observations, we establish quite often troubles of secretion among hystericals. Hypnotists have made very exact remarks on this point.

I shall point out,—said M. Despine,—some few phenomena, but little known, which appear to me to be related to the lack of perspiration of the skin which is generally to be met with among persons attacked by those grave nervous affections which I have found among all my cataleptic patients: the

[1] Briquet, *op. cit.*, p. 481.

dryness and woolliness of the hair, the burning heat of the skin . . . the absence of odour of the armpits and feet. . . .[1]

It is true, in fact, that the perspirations are often much diminished, but one may also establish the contrary fact. We have seen an hysterical woman, a total anæsthetic, who for two years had extraordinary sweats, enough to wet all her clothing; the sweats disappeared suddenly, when, in consequence of an emotion, delirious attacks developed. Has not, indeed, coloured sweat been pointed out among hystericals?[2] All other secretions may present pathological modifications.

The exact studies concerning hysterical atrophies are recent, but the fact, in its general character, was long ago observed. M. Despine (d'Aix), in the same passage which we have just quoted, describes also, perhaps with a little naïveté:

the hairiness of the legs is greater than is common with the generality of women; the practical absence of growth in their nails in both hands and feet, particularly when these members are paralysed. . . . A patient remarked herself that she cut the nails of her left hand but once, while, within the same time, she was obliged to cut those of her right hand three times.[3]

It is enough to recall the beautiful works of Charcot, Babinski, Gilles de la Tourette, Dutil, Souques, about muscular atrophy among hystericals. These, too, are phenomena which, we think, require still much study, but which may be legitimately connected with hysteria.

This short résumé has no other purpose than to show how, by connecting hysteria with the group of mental

[1] Despine (d'Aix), *Traitement des maladies nerveuses par le magnétisme*, 1840, p. 222. Même remarque dans l'ouvrage curieux du Dr. Pétetin sur l'electricité animale, p. 110.

[2] V. Fouré, "De la chromhydrose."

[3] Despine (d'Aix), *op. cit.*, p. 222.

diseases, we should not forget the numerous organic symptoms that are established with these patients. How should we interpret them ? Shall these new facts make us give up our past definitions ? Let us observe, to begin with, that a certain number of these facts must probably be related, more or less consciously, to persistent, fixed ideas, as well as the paralyses and the contractures explained by M. Charcot. In pointing out the importance of isolation in the treatment of hysterical anorexia, M. Charcot showed that the psychical element plays, in this disease, a predominant part.[1] "To my mind," wrote M. Sollier, "there is but one kind of nervous anorexia, namely, mental anorexia." [2]

We might perhaps here have a few restrictions to make, for all anorexias are not alike. If many patients refuse to eat because of a fixed idea, others accept food, then reject it because of certain spasms of the œsophagus, of the stomach, of the diaphragm, or even of the muscles of the abdomen. They are not always phenomena absolutely alike, but it is not the less true that these spasms themselves may be provoked and modified in a manner more or less direct by the ideas of the subject, as it may be very clearly demonstrated by the experiments of suggestion. Experiments of the same kind have provoked modifications in the menstrual period, grave vascular modifications capable of producing upon the skin the erythema of a blister or the phlyctenulæ of burns.[3] These experiments, of course, have to be made over again; they have yet to be verified and interpreted, but they show us at least that we do not yet entirely understand the enormous influence of the thought on the body.

[1] Charcot, *Mal. du. syst. nerv.*, iii., p. 238.

[2] Sollier, "L'anorexie hystérique," *Revue de médecine*, 1891, p. 626.

[3] Beaucoup de ces expériences sont résumées d'une manière intéressante dans le travail de M. Myers, "Subliminal Consciousness," *Proceedings of the Society for Psychical Research*, 1892, p. 308.

The following observation shows us a fact of the same sort, which occurred naturally. Isabel, whom we had not seen for a year, came back to the Salpêtrière, because for a fortnight she had had every morning nose-bleeding and did not know what to attribute it to. Put into a somnambulic state, she related that a fortnight before she found herself mixed up in a street quarrel; becoming strongly excited she began to bleed at the nose. Since that, she has dreamed every morning of this tussle, and her dream has always ended with nose-bleeding, which awakened her. The modification of the dream causes the bleeding to stop, which might otherwise have long resisted other therapeutics. Many of the organic phenomena which we have pointed out may then later become related to fixed ideas, modifying even visceral functions.

A second category of facts may be interpreted differently. Hystericals have not only fixed ideas; they have also persistent emotions, and emotions are complex states of the whole organism in which both the physiological and the psychological phenomena are intimately blended. Certain physiological troubles of hysteria resemble closely the troubles which accompany the emotions. MM. Oppenheim and Strümpell[1] have justly insisted on this very point. Is it necessary to recall the emotive erythema, the dryness of the mouth through fear, the vomiting through disgust, the emotional icterus, etc.? Our knowledge touching the psychology of emotion is insufficient to explain the details of the facts, but we suspect enough of them to believe that this study will later explain many modifications apparently purely physical, and this category of phenomena would then still be connected with our general conception of hysteria.

If there remain unexplained phenomena, and we be-

[1] Oppenheim, *op. cit.*, p. 4; Strümpell, *op. cit.*, p. 7.

lieve there are such, we must, in order to understand them, remember certain general remarks which were made concerning all mental maladies. These maladies depend on unknown alterations of the brain, and it is not likely that these alterations, whatever be their cause, are absolutely isolated in an entirely healthy organism. The actions and reactions of the various parts of the nervous system and even of all the organs, one upon the other, are so numerous that insufficiency in the working of the cerebral apparatus is accompanied by many other troubles. They are established in melancholias, manias, which, yet, are considered mental diseases. Why should they not be seen in hysteria ? The lack of nutrition, the diminution of excrementitious matter, the anæmia, the very predisposition to infectious maladies, evident in certain cases, nowise astonish us in this disease. In certain cases we may be able clearly to establish intoxications, alcoholism, or saturnism, infections, such as syphilis, the grippe, typhoid fever especially, phenomena of autointoxication, diatheses, even like arthritism, which will precede, accompany, and even provoke hysterical phenomena. Some day, perhaps, these physiological modifications, which accompany cerebral insufficiencies, will be determined in a manner precise enough to enable us to show a fundamental physiological phenomenon, to which all the details of the delirium of persecution may be related, and another by which all the phenomena of hysteria may be explained with precision. We shall then have a physiological definition of hysteria. We think that at the present day such a definition would be extremely vague and would not clearly embrace the characteristic phenomena of the disease. Can one be satisfied, for instance, with constantly repeating the same word, " autointoxication," to explain contractures, paralyses, attacks, deliriums ? We know that one and the same intoxication may give rise to cerebral maladies, some very

different from others, and it will always be necessary to describe their characters clinically. If we admit, once for all, that a mental malady is a cerebral malady and that it is always accompanied by a physiological train of phenomena, we shall understand that a psychological definition is, even at this day, the formula best able to sum up, simply from a clinical point of view, the great majority of hysterical symptoms.

Let us now look at the problem from another side. Is not this conception of hysteria, which is sufficiently general to embrace most of its known symptoms, now too broad?—does it not bring under the title of hysteria a quantity of accidents which belong to other maladies? Undeniably; M. Mœbius has already very correctly observed that,[1] for some years past, the domain of hysteria has considerably increased. This term applied at first only to women complaining of pains, symptoms having relation to the genital organs, and special attacks,—that is to say, to but a small number of patients; next, it was applied to children, to men, to patients without genital troubles and without attacks; in a word, to a much larger number of persons. We establish this movement of extension and we believe that it will continue still more, and that numerous tics, pains, fixed ideas, will soon be very legitimately connected with hysteria. This is, indeed, a curious fact in the history of medicine. It has a great significance and shows once more the greater and greater part pathology is playing in the phenomena of the mind, the importance psychiatry is assuming. There will certainly come the time when hysteria will be analysed, and it is not impossible to foresee from now on certain subdivisions which will be later established. It has been so in all the great medical classifications, for nephritis and atrophies the same as for the mental maladies. M. Paul Richer has recently put forth a very interesting

[1] Mœbius, *op. cit.*, p. 5.

hypothesis. Besides the motor troubles of psychic origin, he admits varieties of paralyses and contractures escaping from the influence of the idea, the dynamic lesion of which should be sought in the inferior parts of the cerebro-spinal axis.[1] If this supposition should be verified there would be cause to separate from common hysteria a very distinct malady. We cannot to-day enter into these distinctions; it will be sufficient to try to understand first the common characteristics of the large groups. We therefore wish at present only to tell precisely how, and how far we are disposed, to broaden the field of hysteria.

One of the discussions concerning the limits of hysteria was provoked by the study of somnambulism. Since people have become interested in this phenomenon it has been found that it can be established and induced in a great number of persons; and the question arose whether these persons were patients and what their malady was. In order to study this question we must nowadays first make a distinction which has become more necessary than ever. We are speaking of somnambulism and not of hypnotism. This latter term has lost all precision of meaning; it is applied to the sleeping child, to the patient who takes his medicine, as well as to a subject dazzled by a continuous fixation and to the hysterical in ecstatic attack. We nowise deny that the observation of all these very real facts may furnish interesting details for the study of sleep, of faith, of vertigo, the fatigues of attention, etc. But we do not study here all these questions; we speak of a particular fact and of much more precision; we speak of somnambulism, properly so called. Somnambulism is for us a second psychological existence, clearly distinct from the first and alternating with it, a state in which the intellectual phenomena are sufficiently developed for the subject to perceive the sens-

[1] Paul Richer, *Paralysies et contractures hystériques*, 1892, p. 1.

ations, understand even the signs and the language, but which is nevertheless followed by a complete amnesia when the subject returns to his normal state, and the remembrances of which cannot be recovered except in another analogous state.

We have seen that somnambulism thus understood is found with hystericals, and that it is surrounded by symptoms and accidents clearly hysterical; but we have been able to maintain with probability a clearer and more general opinion.

Somnambulism is hysterical not only because it exhibits hysterical symptoms. In itself it presents in the most perfect manner the essential character of all the phenomena of that malady, and this symptom alone embraces, we think, all the others.

In making this declaration, we should only hesitate to think of some accident as yet incompletely analysed—the ambulatory automatism or the flights of the epileptics. The description of this phenomenon, which we have not ourselves observed, looks strangely like that of hysterical somnambulism, and the psychological diagnosis appears to us very difficult. We have, therefore, read with curiosity a thesis by M. Saint-Aubin, who seems to have proposed this diagnosis to himself for discussion.[1] Unfortunately, the author only describes hystericals and hardly touches upon the difficult problem. We are obliged to be satisfied with the somewhat vague signs already given by M. Jules Voisin,[2] according to the commemoratives, the nature of the accidents, which precede or terminate the second state. We insist particularly with this author on the inco-ordinate character, the unreasonableness of the epileptics' impulsive acts. A truly

[1] Louis Saint-Aubin, *Des fugues inconscientes hystériques et diagnostic différentiel avec l'automatisme de l'épilepsie*, 1890.

[2] Jules Voisin, "Distinction de l'automatisme hystérique et de l'automatisme épileptique," *Congrès de médecine mentale*, 1889.

epileptic automatism should be, we think, very short, without reasoning, without intelligent combination of acts; should be *en rapport* with the circumstances; and, to confess all our thought, should be a complete flight during whole days in which the subject, speaking and acting apparently like a normal person, appears to us to belong far more to hysteria than epilepsy. While taking note of this difficulty, which it was proper to point out, we may conclude on the first point and say that somnambulism comes wholly within the domain of hysteria. We might repeat the same discussion in regard to the automatic writing of mediums and the hallucinations developed by "crystal gazing." These phenomena present themselves generally with subjects offering other hysterical symptoms,[1] and, moreover, these phenomena present in themselves what is essential in hysteria, in anæsthesias, amnesias, subconscious ideas, etc. We accept, then, on this point the broadening of the conception of hysteria, and we bring within its domain somnambulisms, automatic writings, certain hallucinations, and, in general, all those manifestations *en rapport* with subconscious psychological phenomena.

If we continue these studies of diagnosis, we meet other mental states which we must compare with those of the hysterical. In certain intoxications, that of hashish, of alcohol principally, a drunkenness and delirium are produced which are very often similar to hysterical states. We had formerly insisted on suggestibility and the very clear undoubling (dédoublement) of the personality, which we can establish during the alcoholic delirium.[2] Since that, M. H. Colin and M. L. Laurent[3] have published very precise observations touching the

[1] Charcot, *op. cit.*, iii., p. 228; *Autom. psych.*, p. 404.

[2] "Actes inconscients," *Revue philosophique*, 1888, i., p. 251.

[3] H. Colin, *État mental des hystériques*, 1890, pp. 39, 41; L. Laurent, *États seconds*, 1892, pp. 35, 41.

same facts. We think that in certain cases the disintegration of the mind caused by alcoholism or any other intoxication may be very durable and take altogether an hysterical form. In this case, whatever be the provocative agent, it is necessary to acknowledge that we have to do with hysteria.[1] But oftener yet the distinction may be made either by the nature of the delirium, or, still better, by the transient character of the mental disintegration. This diagnosis of hysteria and toxic deliriums teaches us, then, that in the definition of hysteria we must add one more element—duration,—namely, the permanency for a considerable length of time of the undoubling (dédoublement) of consciousness.

The study of another category of patients raises a far more interesting problem and one much more difficult to solve—those very numerous patients, namely, on the limits of insanity, who present symptoms apparently very varied, but having among them incontestable relations, as, for instance, the delirium of doubt, the craze called conscious or argumentative; obsessions, impulsions, phobias, etc. These subjects, although very different, have been nearly always gathered into one group alone by modern authors, but this group received different names, according to the theories of the authors. In France, we generally designate these affections by the name of delirium of the degenerates. In Germany, they call those patients delirious neurasthenics. Not to take sides, without sufficient discussion, in the quarrels to which these several appellations give rise, we shall simply designate all these persons by a name which has been already used and which suits them very well. We shall just call them psychasthenics. Formerly these psychasthenics were deliberately ranked with the insane, were distinctly separated from the hystericals, simple neuropaths; but now that hysteria itself is considered a mental

[1] Georges Guinon, *Les agents provocateurs de l'hystérie*, 1889, p. 163.

disease, does this separation remain sufficiently clear for those two categories of patients to continue in classifications so completely independent of each other ?

Evidently not. There are, in our opinion, between the two groups the closest relations, and it is because of having mistaken these relations that we became often involved in interminable discussions. First, it is impossible to deny that a very great number of patients belong simultaneously to both classes. Many hystericals, as M. Tabaraud [1] and M. Colin [2] have shown, by excellent observations, have obsessions, impulsions, phobias of all kinds. We shall go a little farther than even these authors in saying that these symptoms, pointed out by them in the case of some hystericals, exist in reality more or less dissembled with nearly all. It is even those fixed ideas, as M. Charcot established formerly, which account for the accidents of hysteria. On the contrary, again, it is very rare to meet a psychasthenic patient who is, if we may so speak, a pure type of this affection and who does not present anæsthesias more or less clear, amnesias at least transitory, subconscious acts; in a word, symptoms of hysteria. There are even certain symptoms which are always common to both categories of patients, namely, the phenomena which result from abulia. Several persons wondered that, in our work on the mental stigmata of hysteria, we should have described the troubles of the will and of the attention, the hesitations of the voluntary movements, the powerlessness of the attention to understand and retain such ideas, as the stigmata of hysteria. They are, they say, symptoms belonging to the insane, which characterise hypochondriacs and especially doubters and the obsessed. Perhaps, for we do not hesitate to recognise the correctness of a criticism, we

[1] Tabaraud, *Les rapports de la dégénérescence mentale et de l'hystérie*, 1888.

[2] H. Colin, *L'état mentale des hystériques*, 1890.

have not said clearly enough that this symptom was not always characteristic of hysteria; that it was to present itself in a special manner to serve as a diagnosis of hysteria, and that, in a word, it was a commonplace symptom belonging to many mental maladies.[1] But, however the case may be, we do not think that this characteristic of the description of hystericals can be ignored; it is found with all those patients in the highest degree; it plays in all accidents a chief part; it is here abulia, which, as ever, stands for the diminution of the actual synthesis of the psychological phenomena which permit the development of automatism—that is to say, the reproduction of the old phenomena under the form of fixed ideas and delirium. Abulia is a common characteristic with hystericals and psychasthenics.

If we compare phenomena which, in these two maladies, are incontestably different, it will be observed that there is nevertheless an essential analogy. It would not be impossible to arrange the symptoms of these patients, two by two, showing that to each hysterical symptom there corresponded a psychasthenic symptom, not identical, but very analogous in its psychological mechanism. To anæsthesias there would correspond absence of mind and errors of sensations; to amnesias, doubts; to paralyses, hesitations of the voluntary movement, which have been sometimes confounded with deliriums of contact; to contractures, fixed ideas; to convulsive attacks, certain attacks of ideas preceded by an anguish, as of an aura; to somnambulisms even, strange periods when the patient no longer knows himself, finds his personality changed, etc. If we study the mechanism of all these phenomena, we find on either side the diminution of the synthesis and the emancipation of the automatic phenomena. It seems to us, therefore, impossible

[1] We have, however, repeatedly dwelt on this point. *Stigmates mentaux de l'hystérie*, pp. 117, 221, above.

completely to separate two maladies so near each other. We think that they are both a part of a large class of mental diseases very much in the same line, which we purposed calling the diseases of mental disintegration.

We are disposed to believe,—we used to say in times past,—that the phenomena of automatism and disintegration depended upon a condition that was diseased, but not therefore solely hysterical. This condition would on the contrary be more widely spread than hysteria; it would comprise in its manifestations hysterical symptoms, but it would also reveal itself by fixed ideas, impulsions, anæsthesias due to absence of mind, automatic writing, and lastly somnambulism itself.[1]

We are glad to find ourselves agreeing on this point with several other authors, who have also affirmed this relation of the two maladies. "The largest portion of hystericals, not to say all," wrote M. Legrain, "are hereditary degenerates," and M. Tabaraud added: "From that to saying that hysteria is in some respect part of degeneracy, that it ought to be considered one of its syndromes, there is but a step."[2] "Degeneracy and hysteria," said also M. Roubinovitch, in a work presented to the Société médico-psychologique, "seem to have mutual affinity; . . . hysteria appears to be thus the result of a logical evolution of degeneracy."[3] The assimilation of hysteria and of psychasthenia has struck all those who have studied the nature of those two mental maladies.

To bring together, compare, and classify is not to confound; on the contrary, we do not mean entirely to identify a simple hysterical, with her anæsthesias, her attacks, and her contractures, with a psychasthenic, who presents

[1] *Autom. psych.*, p. 451.
[2] Tabaraud, *op. cit.*, p. 28.
[3] *Annales médico-psychologiques*, 1892, ii., p. 143.

nothing but doubts, impulsions, and fixed ideas. There is not, however, between these two categories of facts, the great difference which was formerly supposed to exist, when it was said that the first were physical phenomena and the others moral phenomena. Really, these factors are psychological, the one as well as the other; but important differences may exist even between psychological factors. The lack of mental synthesis, the disintegration of the mind, does not present itself the same way in the two cases. In hysteria the psychological phenomena, not being of a nature to be fully reunited, clearly separate into several groups in a way independent of each other. The personality cannot perceive all phenomena; it does, indeed, sacrifice a few; it is a kind of autonomy, and these abandoned phenomena develop separately without the subject's having any knowledge of their activity. The anæsthesia is, therefore, clear, the amnesia absolute, the attack and the somnambulic sleep well distinguished from the waking state; the fixed ideas are not expressed, nor even known by the subject. The delirium exists in the mind of the subject without his being conscious of it, and while he goes on talking very reasonably. A hysterical patient spits out her food as soon as she puts it in her mouth, and yet she seems to make every reasonable effort to eat. Nevertheless, she rejects the food in spite of herself, without meaning to do so, or thinking of doing it; you think, while watching her, and she thinks, herself, that the trouble lies in deglutition or in some accident purely physical; you would be wrong to say that she is crazy. She is, notwithstanding, in full delirium. Since her last attack she has been constantly dreaming that her mother in heaven invites her to join her, and tells her to let herself die of hunger as fast as possible, and her vomiting is provoked by nothing else than this delirium. But this delirium is separated from the normal consciousness; it is subconscious;

the bystanders and the patient herself are ignorant of it. "Hystericals," say MM. Breuer and Freud, "are reasonable beings when awake, and crazy in their hypnoid state."[1] This clear separation of the psychological phenomena may be expressed schematically by saying that in hysteria there is the formation of two independent personalities. The disintegration takes the form of the undoubling (dédoublement) of the personality.

It is quite otherwise with the psychasthenics. Their mental disintegration does not occur in the same way; it seems that their personality does not resign itself to the necessary sacrifices and that it abandons the phenomena to their automatic development in part only. There is no longer any very clear anæsthesia or amnesia. They are always incomplete and take the form of an absence of mind and of a continuous doubt. Instead of passing readily from one idea to another, forgetting wholly the preceding one, the psychasthenic remains always undecided between the different ideas. Deliriums, unfortunately for the patient, do not remain subconscious; they invade consciousness every instant; they mix with the other thoughts and create a much more considerable and general disturbance of thought. The patient, therefore, who comes complaining, whining, that it is in spite of herself that she thinks of betraying her husband, and that she is obsessed by this continuous idea, appears to us much more crazy than the hysterical who vomits. The subject herself feels much more ill, and never displays the fine indifference of the hystericals. Sometimes, although less frequently, the disintegration with this patient goes so far as to form different personalities, but they are never independent as with the hysterical. The patient feels this development of another personality within herself, and she talks constantly about possession, while the hysterical, the most undoubled (dédoublé), the most pos-

[1] Breuer et Freud, *op. cit.*, p. 8.

sessed in reality, is generally ignorant of this division of her mind.

We cannot study here this new form of mental disintegration which characterises the psychasthenics, nor indicate its degree of gravity and its consequences. It will be sufficient to remark that it is different from that which has been established for the hystericals. We may then conclude with M. Colin,[1] that "hysteria has its marked place in medical science and its own characteristic signs." It is not necessary to deny the moral character of hysteria to preserve for it its place; it is enough to distinguish mental diseases from each other.

It is useless to take up again a discussion we have already often had concerning the relations of hysteria to the normal state. We have shown that in absence of mind, habits, passions, in the psychological automatism of the normal man, we find again the germ of all hysterical phenomena. Some authors have been surprised at it and make use of remarks of the same sort to represent as normal persons decided hystericals, or *vice versa*. This comparison need cause no surprise. "We must admit in a moral sense the great principle universally admitted in a physical sense since M. Claude Bernard —namely, that the laws of disease are the same as those of health, and that there is in the former but the exaggeration or the diminution of the phenomena which were already found in the latter."[2] It is these degrees of the phenomena which we must be willing to recognise in order to distinguish an absence of the mind from an anæsthesia, an emotion from an attack, a dream from a somnambulic sleep. The distinction will always be difficult if one is merely satisfied with studying uncertain and doubtful cases, and easy if willing to begin studying the "type cases," and compare the former with the latter.

[1] Colin, *op. cit.* [2] *Autom. psych.*, p. 5.

We have enlarged, upon one point, the conception of hysteria in connecting with it somnambulisms and subconscious acts; but we have limited the extent of this disease in distinguishing it from deliriums and the alienations which appear to come nearest to it. Mental disintegration is more permanent in hysteria than in deliriums; it is much clearer and more complete in this malady than in the psychasthenic states.

RÉSUMÉ

There is no call in this work for dwelling on the etiology or the evolution of hysteria; it suffices to recall well-established notions. Pathological heredity plays in hysteria, as in all other mental maladies, a rôle absolutely preponderant.[1] A very great number of circumstances play the part of "provocative agents," and manifest by accidents this latent predisposition; they are hæmorrhages, wasting and chronic diseases, infectious diseases, typhoid fever in particular, and, in certain cases, the autointoxications, the organic diseases of the nervous system; various intoxications, physical or moral shocks, overwork, either physical or moral, painful emotions, and especially a succession of that sort of emotions the effects of which are cumulative, etc. It is easy to see that all these provocative agents are of the same character; they weaken the organism and increase the depression of the nervous system. There is, above all, an age which in this respect is particularly critical—the age of puberty. We speak here not of physical puberty, which has, however, a great influence, but of a state which comes a little later and which might justly be called moral puberty. It is an age slightly variable according to countries and surroundings, when all the greatest problems of life present

[1] Briquet, *op. cit.*, p. 84; Georges Guinon, *Les agents provocateurs de l'hystérie*, 1889, p. 285; Pitres, *op. cit.*, i., p. 16, etc.

themselves simultaneously; the choice of a career and the anxiety about making a living; all the problems of love, and for some the religious problems. These are preoccupations which invade the mind of young people and completely absorb their feeble power of thought. These thousand influences manifest a *psychological insufficiency* which remains latent during the less difficult periods. In a mind predisposed by hereditary influences, this psychological insufficiency develops, takes a special form, and presently manifests itself by an ensemble of symptoms which we call hysteria.

The word "hysteria" should be preserved, although its primitive meaning has much changed. It would be very difficult to modify it nowadays,[1] and, truly, it has so great and so beautiful a history that it would be painful to give it up; but since every epoch has given it a different meaning, let us try to find out what meaning it has to-day. In order to try to summarise what we have borrowed from all these recent studies concerning hysteria, it is sufficient to gather up the conclusions of our foregoing paragraphs.

Hysteria,—we can say,—*is a mental disease belonging to the large group of the diseases due to weakness, to cerebral exhaustion; it has only rather vague physical symptoms, consisting especially in a general diminution of nutrition; it is above all characterised by moral symptoms, the principal one being a weakening of the faculty of psychological synthesis, an abulia, a contraction of the field of consciousness manifesting itself in a particular way; a certain number of elementary phenomena, sensations and images, cease to be perceived and appear suppressed by the personal perception; the result is a tendency to a complete and permanent division of the personality, to the formation of several groups independent of each other; these systems of psychological factors alternate some in the wake of the others or coexist; in fine, this lack of*

[1] Mœbius, *op. cit.*

synthesis favours the formation of certain parasitic ideas which develop completely and in isolation under the shelter of the control of the personal consciousness and which manifest themselves by the most varied disturbances, apparently only physical.

If we would sum up in two words this rather complex definition, we should say:

Hysteria is a form of mental disintegration characterised by a tendency toward the permanent and complete undoubling (dédoublement) of the personality.

Permit us, in closing, to repeat what we have said at the outset. A definition of this kind does not pretend to explain phenomena, but simply to summarise the greatest possible number of them. It will soon, we hope, be superseded by a more comprehensive definition, one that will contain all the preceding facts and add to them still more phenomena—such as the physiological modifications which accompany and provoke this cerebral insufficiency. We only hope that this wholly provisional definition may now render some service and give somewhat greater precision to the innumerable remarks made during a long period by physicians and psychologists regarding the mental state of hystericals.

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